

**H & D Physical Therapy**

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# H & D Physical Therapy

## Patient Medical and Physical History Questionnaire

The purpose of this questionnaire is to identify medical complication, and common functional activities that give you difficulty or discomfort. This will help to establish medical necessity of treatment as well as help set functional goals.

<b>Patient Name:</b>						
Please <b>circle</b> your medical problem and describe the status		Please indicate which of the Physical Activities listed below are a problem by <b>check</b> the reason(s)				
MEDICAL PROBLEMS	DATE OF ONSET AND CURRENT STATUS	PHYSICAL ACTIVITIES	Reason you are having difficulty			
			Pain	Motion	Weakness	Fatigue
Abnormal Posture		Lying in bed				
Allergies		Rolling over in bed				
Anemia		Sitting-up from bed				
Angina or Chest Pain		Sitting in chair				
Arthritis or pain in a joint		Standing-up from chair				
Asthma		Getting down on floor				
Cancer		Getting up from floor				
Chronic Bronchitis		Squatting or kneeling				
Circulatory Problems		Driving car				
Dementias		Getting in & out of car				
Depression		Balancing				
Diabetes Mellitus (DM)		Standing				
Difficulty Walking		Walking				
Discomfort in Middle or Lower Back or Radiating to the Legs		Jogging				
Emphysema		Running				
Fracture		Jumping				
Headaches		Climbing stairs				
Heart Disease (heart attack, abnormal rhythm, or congestive heart failure)		Climbing ladder				
Hepatitis		Bending				
Hypertension (High Blood Pressure)		Twisting or Turning				
Kidney Disease		Reaching with arm(s)				
Nervous or Musculoskeletal Symptoms		Reaching with leg(s)				
Obesity		Pushing				
Open Skin Sores		Pulling				
Osteoporosis		Lifting overhead				
Pacemaker		Lifting to waist height				
Persistent Mental Disorders		Lifting from floor				
Pneumonia		Carrying				
Polio		Throwing				
Rheumatic/Scarlet Fever		Gripping objects				
Rheumatoid Arthritis and other conditions affecting multiple joints		Using hands & fingers				
Shortness of Breath		<b>Others: Please List</b>				
Stomach Problems						
Stroke						
Urinary Tract Infection						
Vestibular (Inner Ear) Disorders						

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Patient Medical and Physical History (continued)

Are you pregnant? Yes / No If yes, how many months? \_\_\_\_\_

Have you been discharged from a hospital or skilled nursing facility in the last 30 days?  
Yes / No

If yes, date of discharge \_\_\_\_\_, name of hospital or skilled nursing facility

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Please list your surgical history:

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Please list your present medications below:

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Date of onset of injury, illness or pain requiring physical therapy:

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Special tests performed (i.e. X-ray, CT Scan, MRI):

---

Date(s) and Result (s):

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Have you had any adverse reactions to past physical therapy? Yes / No If yes, please explain. \_\_\_\_\_

---

Have you been treated for this same problem already in 2007? Yes / No

If yes, when was your treatment? Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

How many treatments did you receive? \_\_\_\_\_

Was the treatment successful? \_\_\_\_\_

What exercises or sports have you or do you participate in?

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What do you hope to achieve as a result of your course of physical therapy with us?

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Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**We appreciate the opportunity to serve your physical therapy needs!**

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# H & D Physical Therapy

## Cancellation Policy v2.1 - PLEASE READ

### To our patients regarding cancellations and no-shows

The following are our policies regarding cancellations and no-shows. We take this subject seriously at our practice because it can make the difference between whether you succeed in your treatment or not. Usually, your referring doctor and/or your therapist has prescribed a set frequency of treatment. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow our therapist's instructions and we will be able to help you achieve your goals in treatment.

We require 24 hours notice in the event of a cancellation. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get in the full prescribed number of treatments that week whenever possible.

**There is a \$100.00 charge for a cancellation without proper notice. This charge will not be covered by insurance. It will have to be paid by you personally.**

For Worker's Compensation and Personal Injury patients, documentation of any missed appointments is forwarded to your Case Manager and Primary Physician and this could jeopardize your claim.

You may need to see a therapist other than the one who normally treats you if you do re-arrange your appointment. All of our therapists are experienced professionals, and they will study your treatment notes as well as discuss your program with your primary therapist, so you will be in good hands. You will return to your original therapist in the next regularly scheduled visit.

Please understand that it is typical for your pain patterns to fluctuate throughout your treatment program. Either condition can seem to be a reason not to come in: a) you're feeling worse and think the treatment is not working or, b) you're feeling better and it's a great day for wind-surfing. Neither of these conditions is legitimate as a reason not to come. For example, if you're in pain, come in and let us help you, or if you're now pain-free, this is an ideal time to begin doing some real correction of the underlying causes of your problem and educate you so you won't re-injure yourself.

When you don't show as scheduled, three people are hurt:

You because you don't get the treatment you need as prescribed by the doctor and/or PT.  
The therapist who now has a space in his/her schedule since the time was reserved for you personally.  
Another patient who could have been scheduled for treatment if you had given proper notice.

Please cooperate with us in this regard. We're looking forward to working with you.

I have read and understand the above.

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

<first> <last>

Parent Signature (if minor) \_\_\_\_\_ Date \_\_\_\_\_

## **H & D Physical Therapy**

### **Patient Financial and Insurance Agreement 1.0**

H & D Physical Therapy is committed to providing you with the best possible care. If you have health insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Co-insurance expected when services are rendered \$\_\_\_\_\_

Payment for non-covered services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, MasterCard, Visa and American Express. We will process and submit your insurance claim form for your reimbursement.

Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1 ½% per month.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

- 1. Your insurance is a contract between you, your employer and the insurance company. H & D Physical Therapy is not a party to that contract.*
- 2. Our fees are generally considered to fall within the acceptable, usual, customary, and reasonable range by most companies, and therefore are covered up to the maximum allowable amount determined by each carrier.*
- 3. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.*

We must emphasize that, as physical therapy providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

#### **Please read and sign below**

I have read and understood the above information. I agree to pay and bear responsibility for costs and fees to collect for these services rendered.

Authorization is given to **H&D Physical Therapy, PLLC**, and all providers, to release a copy of my (or my child's) records and/or diagnosis or treatment to my insurance carrier, the Social Security Administration or its intermediaries or carriers including, but not limited to, Medicare, Medicaid, third party payers or others responsible for insurance claims and investigations. This includes release of information to other health care practitioners or wellness providers as appropriate, and includes electronic transmission and fax transmission of medical information. I authorize **H&D Physical Therapy, PLLC** to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

I hereby authorize payment of insurance benefits directly to **H&D Physical Therapy, PLLC** and the providers of my treatment which would otherwise be payable to me.

I understand that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I agree to pay and bear responsibility for costs and fees to collect for these services rendered. Acknowledgement is made that payments for services rendered are primarily the responsibility of the patient presenting for treatment.

I have read all of the information included in this document and agree to notify you of any changes in my status, insurance coverage or any other information.

**Prescriptions:** I acknowledge that it is my responsibility to know when my prescription expires and to obtain any and all renewals in a timely fashion. I understand that my insurance cannot be billed for my physical therapy treatment without a valid prescription from the referring medical professional.

If you have any questions about the above information or any uncertainty regarding your insurance coverage, please don't hesitate to ask us. H & D Physical Therapy is here to help you. The telephone number to our Business Center is (212) 499-0876.

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Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent Signature (if minor) \_\_\_\_\_ Date \_\_\_\_\_

## H & D Physical Therapy

### Keeping Your Credit Card on File with H&D

#### Questions & Answers

**Q. May I set a limit for the amount H&D Physical Therapy can automatically bill?**

A. Yes. Please indicate the amount here: \_\_\_\_\_

**Q. Will I receive a statement or receipt for the charges automatically billed to my credit card?**

A. You will receive a copy of this Credit Card Authorization Form. All authorized charges will appear on your monthly statement, just like any other purchase.

**Q. What is an automatic billing procedure?**

A. It is a convenient payment method in which you authorize H&D Physical Therapy to automatically bill your credit card for recurring charges. All charges must be in accordance with your agreement

**Q How does the automatic billing procedure work?**

A. The form is used to automatically bill your account for recurring fees starting from today until you notify us otherwise.

**Q. How do I cancel automatic billing?**

A. Either provide a written 30-day notice to H&D Physical Therapy or contact our billing department at (212)499-0876

#### Authorization for Automatic Payment By Credit Card

Patient Name: \_\_\_\_\_

Printed Name on Credit Card (if different from above):  
\_\_\_\_\_

Cardholders Telephone #: \_\_\_\_\_

Type of Credit Card (please circle one): VISA    MASTERCARD    AMERICAN EXPRESS

Card Number : \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Description of Charges to be billed per visit:

Copay/Coinsurance \$ \_\_\_\_\_ Self Pay \$ \_\_\_\_\_ Other\$ \_\_\_\_\_

I hereby authorize H&D Physical Therapy to charge my credit card for any purchase of their products and/or services. I authorize H&D Physical Therapy to bill the card on file, beginning today until future notice is given. Payment will be processed at the time services are rendered or within one week of the date of service. If H&D Physical Therapy is unable to process my payment, I will be responsible for an alternative payment arrangement and any late fees which result. By signing this authorization, I acknowledge that I have read and agree to all of the above. I acknowledge that all information given is complete and accurate.

Signature of Cardholder: \_\_\_\_\_ Date of Signature:  
\_\_\_\_\_

## **H & D Physical Therapy**

### **Terms and Conditions:**

1. Each payment shall be treated as if the customer had personally issued a written direction authorizing H &D Physical Therapy to charge the amount from the patient's credit card.
2. H&D Physical Therapy reserves the right to discontinue service at any time for unpaid accounts.

# H & D Physical Therapy

## Notice of Privacy Practices v 2.0

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

*At H&D Physical Therapy we are vigilant in protecting patient confidentiality. No information regarding our patients is shared or distributed with any other persons or organizations without the patients' signed authorization. Any questions or comments may be directed to our Privacy Compliance Officer Carol Bloom.*

### **Understanding Your Health Record/Information**

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as:

- a basis for planning your care and treatment;
- a means of communication among the many health professionals who contribute to your care;
- a legal document describing the care you received;
- a means by which you or a third-party payer can verify that services billed were actually provided;
- a tool in educating health professionals;
- a source of data for medical research;
- a source of information for public health officials charged with improving the health of the nation;
- a source of data for facility planning and marketing;
- a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to:

- ensure its accuracy;
- better understand who, what, when, where, and why others may access your health information;
- make more informed decisions when authorizing disclosure to others.

### **Your Health Information Rights**

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522;
- obtain a paper copy of the notice of information practices upon request;

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inspect and obtain a copy of your health record as provided for in 45 CFR 164.524;  
amend your health record as provided in 45 CFR 164.528;  
obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528;  
request communications of your health information by alternative means or at alternative locations;  
revoke your authorization to use or disclose health information except to the extent that action has already been taken.

### **Our Responsibilities**

This organization is required to:

- maintain the privacy of your health information;
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you;
- abide by the terms of this notice;
- notify you if we are unable to agree to a requested restriction;
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

### **Right to Revise Privacy Practices**

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policy will be applied to all protected health information we maintain.

### **Request to Inspect Protected Health Information:**

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the receptionist or privacy officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

### **For More Information or to Report a Problem**

If have questions, comments or would like additional information, you may contact the Privacy Officer at H&D Physical Therapy, PLLC, 12 East 46<sup>th</sup> Street, 8<sup>th</sup> Floor, New York, NY 10017 or call 212-499-0848.

If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

### **Examples of Disclosures for Treatment, Payment and Health Operations**

*We will use your health information for treatment.*

For example: Information obtained by a physical therapist or other member of your healthcare team will be recorded in your record and used to determine the course of

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treatment that should work best for you. Your physical therapist will document in your record his or her expectations. In that way, the physician will know how you are responding to treatment. We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you're discharged.

*We will use your health information to obtain payment.*

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

*We will use your health information for regular health operations.*

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

### ***Other Permitted or Required Uses and Disclosures***

**Business associates:** There are some services provided in our organization through contacts with business associates. Examples include billing services and mailing houses. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

**Notification:** We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

**Appointment reminders:** We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

**Communication with family:** Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

**Research:** We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

**Marketing:** We may contact you to provide appointment reminders or information about treatment alternatives, educational seminars or other health-related benefits and services that may be of interest to you.

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*Social activities:* We may contact you to inform you about social activities such as an invitation to our holiday open house party, birthday greetings and holiday greetings.

*Fund raising:* We may contact you as part of a fund-raising effort.

*Workers compensation:* We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

*Public health:* As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability. For example, we are required to report certain communicable diseases to the state's public health department.

*Correctional institution:* Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

*Law enforcement:* We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

### **Effective Date:**

This notice is effective on or after April 14, 2003.

# H & D Physical Therapy

## Acknowledgement of Receipt v2.0

I acknowledge that I have received a copy of the Notice of Privacy Practices of H&D Physical Therapy, PLLC. I further acknowledge that I have had an opportunity to ask questions about this policy.

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Name of Patient

---

Signature

---

Date

If this acknowledgment is not signed by someone other than the patient, please print the information set forth below:

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Name of Person Signing

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Relationship to Patient

## H & D Physical Therapy

### Referral Information

Please assist us in saying thank you to those who helped you find us by providing the following information.

How did you hear about us? Please check all that apply and provide details where requested:

- The doctor who wrote my physical therapy prescription
- Other doctors: Name(s) \_\_\_\_\_
- I was treated by H&D in the past.
- I was referred by someone who was treated by H&D.  
Name: \_\_\_\_\_
- I was referred by someone who works at H&D.  
Name: \_\_\_\_\_
- I used the internet to find H&D:
  - I visited [www.HDphysicaltherapy.com](http://www.HDphysicaltherapy.com)
  - I used my insurance company's web site to find H&D
  - I used a search engine:

Google	Yahoo	AltaVista
Ask.com	MSN	Excite
  - I found a link to H&D or [www.HDphysicaltherapy.com](http://www.HDphysicaltherapy.com) on another web site:
  - I heard about H&D through a blog. Whose blog(s)? \_\_\_\_\_
- I looked at H&D's web site, but was initially referred to H&D by other means.
- I was referred by my place of employment.  
Name of Person who referred you: \_\_\_\_\_  
Name of Company: \_\_\_\_\_
- Hospital for Special Surgery Rehabilitation Network
- Non H&D Physical Therapists or Physical Therapy Organizations: McKenzie Institute,  
Institute of Physical Art,  
Others: Name: \_\_\_\_\_
- Other Organizations (circle):  
Upledger Institute,  
Faith Based Organizations,  
Other: Name \_\_\_\_\_
- Other Individuals:  
Name of Person who referred you: \_\_\_\_\_  
Discipline (circle): Occupational Therapist, Massage Therapist,  
Personal Trainer, Psychologist,  
Other \_\_\_\_\_

Thank you!

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