West Windsor Plainsboro PT

Patient Information Form

Patient Information

Last Name _____ First Name _____ MI _____

Address _____

Address2 _____ City _____ State _____ Zip _____

Home Phone ( ) - Work Phone ( ) - Cell Phone ( ) -

Date of Birth / / SSN - - Gender _____ Marital Status _____ Email _____

Emergency Contact

Last Name _____ Relationship _____

First Name _____ Phone ( ) -

Employer

Name _____ Phone ( ) -

Address _____

Address2 _____ City _____ State _____ Zip _____

Problem

Problem Description _____ Date of Injury / / Last Physician Visit / /

Referred By _____ Primary Care Physician _____

Latest Referral Information _____ Motor Vehicle Accident _____

Latest Plan of Care _____ That occurred in: _____

Notes: _____

Primary Insurance

Insurance _____ Deductible _____ *Subscriber*

ID _____ Max Benefit _____ Name _____

Group # _____ CoPay _____ CoInsurance _____ Relationship _____

Date of Birth _____

Secondary Insurance

Insurance _____ Deductible _____ *Subscriber*

ID _____ Max Benefit _____ Name _____

Group # _____ CoPay _____ CoInsurance _____ Relationship _____

Date of Birth _____

Tertiary Insurance

Insurance _____ Deductible _____ *Subscriber*

ID _____ Max Benefit _____ Name _____

Group # _____ CoPay _____ CoInsurance _____ Relationship _____

Date of Birth _____

WE WILL SUBMIT CLAIMS TO YOUR INSURANCE CARRIER ON YOUR BEHALF. ANY BALANCE DUE AFTER INSURANCE CARRIER PAYMENT WILL BE YOUR RESPONSIBILITY. ALL ACCOUNTS 30 DAYS PAST DUE ARE SUBJECT TO A 1.5% INTEREST CHARGE PER MONTH.

24 HOURS ADVANCED NOTICE IS REQUIRED IN THE EVENT OF A CANCELLATION.
THERE IS A PERSONAL CHARGE OF $35 FOR A CANCELLATION WITHOUT PROPER NOTICE.

YOUR SIGNATURE INDICATES THAT YOU UNDERSTAND THE ABOVE INFORMATION.

Signature: _____ Date: _____

Notice of Information Privacy Practices
West Windsor - Plainsboro PT Center

I. This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

II. We have the legal duty to safeguard your Protected Health Information (PHI).
We are legally required to protect the privacy of your health information. It includes information that can be used to identify you and that we have created of received about your past, present, or future health condition, the provision of health care to you, or the payment for this health care. We are required to provide you with this notice about our privacy practices.

III. How we may use and disclose your protected health information.
We use and disclose health information for many reasons. For some of these uses or disclosures, we need your specific authorization.

A. Uses and disclosures which do not require your authorization:

1. **For treatment**. We may disclose your PHI to physicians, nurses, and other healthcare personnel in order to provide health care.
2. **To obtain payment for treatment**. We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you.
3. **For health care operations.** We may disclose your PHI, as necessary, to operate this facility and provide quality care.
4. **When a disclosure is required by federal, state, or local law, judicial or administrative proceedings, or law enforcement.**
5. **For public health activities; health oversight activities; to avoid harm; and specific government functions.**
6. **For workers' compensation purposes.**

B. All other uses and disclosures require your prior written authorization.
Other than stated above, we will not disclose your PHI without your written authorization.

The law provides you with several rights with respect to your PHI. You have the right to request, in writing, to inspect and obtain a copy of PHI about you. This does not include information that relates to, and is collected in connection with or in anticipation of, a claim or civil criminal proceeding involving you, or information the release of which is prohibited by law. You must reasonably describe in your written request the information you seek; and the information must be reasonably available and retrievable by us. When permitted, we may charge you a fee to cover the cost of providing the PHI.

You also have the right you request, in writing, that we amend or delete PHI about you that we have in our records if you believe that the information is incorrect or incomplete.

X_____ Date:_____
Your signature indicates that you have read and understood the above information

4/2003

West Windsor Plainsboro
Physical Therapy Center

Credit Card Authorization

Photocopy front and back of card in this box.

I (X) _____ hereby authorize West Windsor-Plainsboro PT Center to make payment on the above credit/debit card to 1) pay my treatment co-pay or co-insurance payment at the time services are rendered and/or 2) satisfy a past due balance that may accumulate on my account.

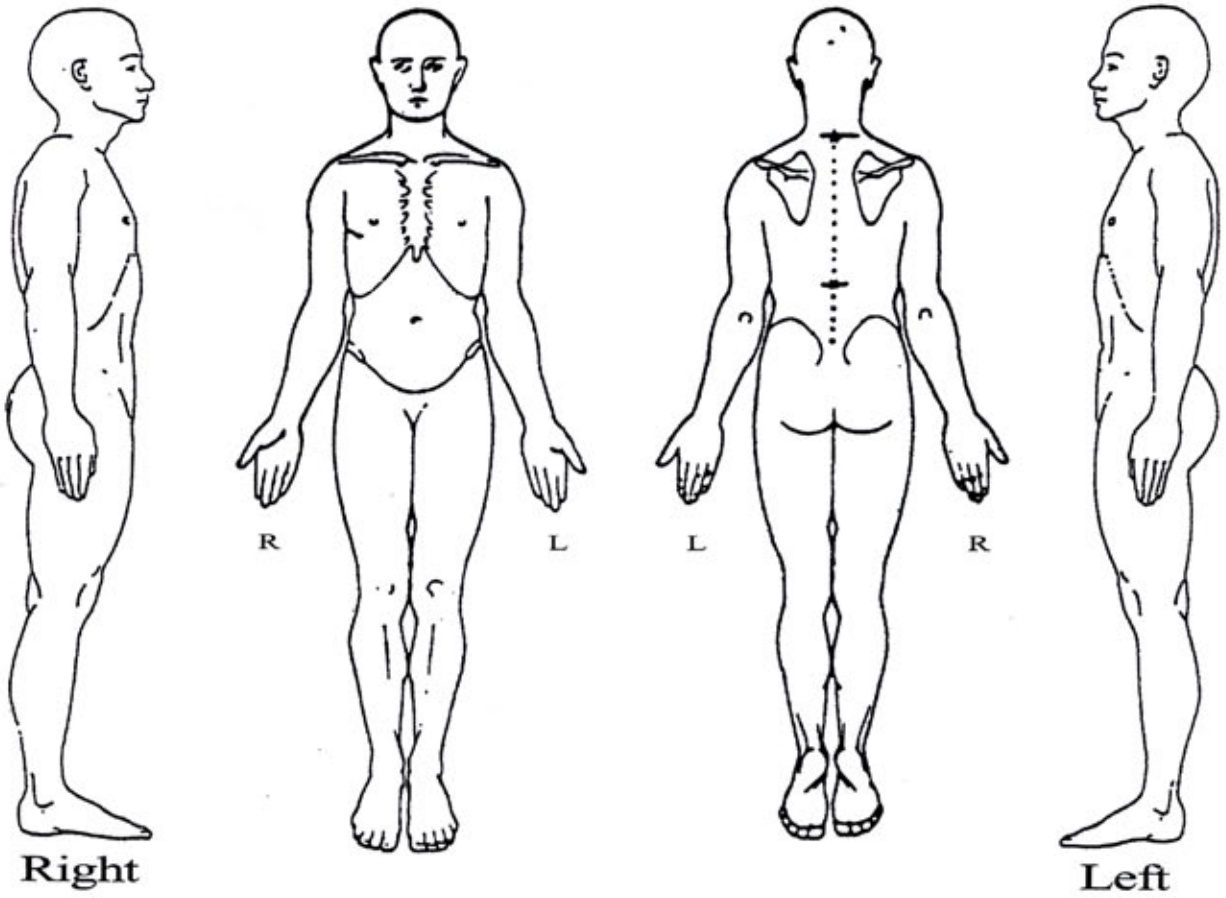
West Windsor Plainsboro
Physical Therapy Center

"DASH" Questionaire

Name:_____ Date:_____

This questionnaire asks about your symptoms as well as your ability to perform certain activities. Please answer ***every question*** (on page 2) based on you condition over the past week by circling the appropriate number. If you did not have an opportunity to perform an activity, make your best estimate on which would would be the most accurate. **It does not matter which hand or arm you use to perform te activity.

Please shade the area of your pain.



Please circle **only one number** for each choice:

Current pain level:
0 1 2 3 4 5 6 7 8 9 10

Pain at its least:
0 1 2 3 4 5 6 7 8 9 10

Pain at its worst:
0 1 2 3 4 5 6 7 8 9 10

"DASH" Questionnaire (page 2)

	No Difficulty	Mild Difficulty	Moderate Difficulty	Severe Difficulty	Unable
1. Open a tight jar.	1	2	3	4	5
2. Write.	1	2	3	4	5
3. Turn a key.	1	2	3	4	5
4. Prepare a meal.	1	2	3	4	5
5. Push open a heavy door.	1	2	3	4	5
6. Place an object on a shelf above your head.	1	2	3	4	5
7. Do heavy household chores (wash walls/floor).	1	2	3	4	5
8. Garden or do yard work.	1	2	3	4	5
9. Make a bed.	1	2	3	4	5
10. Carry a shopping bag or briefcase.	1	2	3	4	5
11. Carry an object over 10 pounds.	1	2	3	4	5
12. Change a light bulb overhead.	1	2	3	4	5
13. Wash or blow dry your hair.	1	2	3	4	5
14. Wash your back.	1	2	3	4	5
15. Put on a pullover sweater.	1	2	3	4	5
16. Use a knife to cut food.	1	2	3	4	5
17. Recreational activities which require little effort (Cardplaying, knitting, etc.).	1	2	3	4	5
18. Recreational activities in which you take force or impact through you're the arm, shoulder, or hand (Golf, tennis, etc.).	1	2	3	4	5
19. Recreational activities in which your arm moves freely. (Frisbee, badminton, etc.).	1	2	3	4	5
20. Manage transportation needs (getting from one place to another).	1	2	3	4	5
21. Sexual activities.	1	2	3	4	5
22. During the past week, to what extent has your arm, shoulder, or hand problem interfered with your normal social activities.	1	2	3	4	5
23. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder, or hand problem?	1	2	3	4	5
24. During the past week, how much difficulty have you had sleeping because of pain in your arm, shoulder or hand?	1	2	3	4	5

	None	Mild	Moderate	Severe	Extreme
25. Arm, shoulder, or hand pain.	1	2	3	4	5
26. Arm, shoulder, or hand pain when performing a specific activity.	1	2	3	4	5
27. Tingling (pins/needles).	1	2	3	4	5
28. Weakness in the arm, shoulder, or hand.	1	2	3	4	5
29. Stiffness in your arm, shoulder, or hand.	1	2	3	4	5

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
30. I feel less capable, less confident, or less useful because of my arm, shoulder, or hand.	1	2	3	4	5

A DASH Score may not be calculated if there are greater than 3 missing items.

Office use only:

DASH DISABILITY/SYMPTOM SCORE=_____