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.

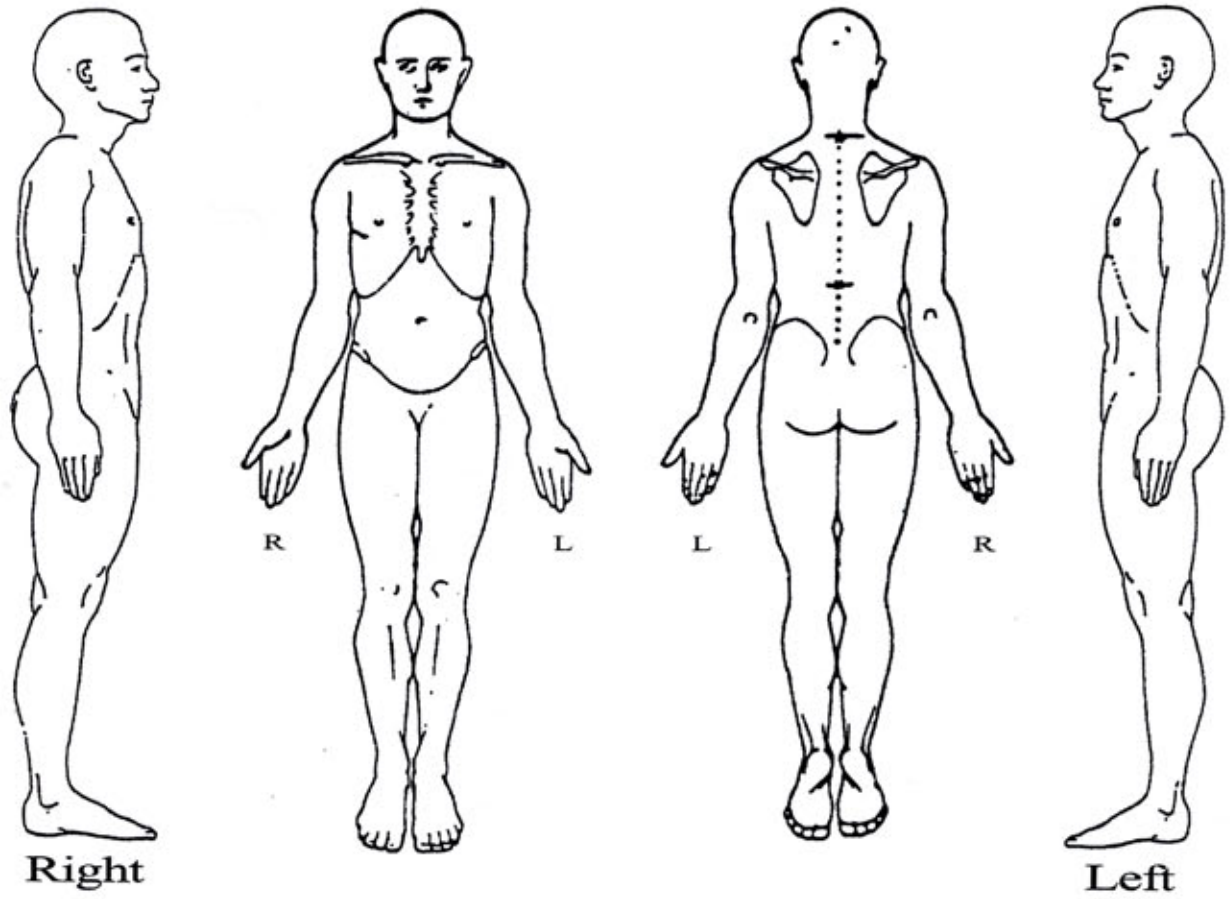
West Windsor Plainsboro
Physical Therapy Center

Lower Extremity Functional Survey

Name:_____ Date:_____

This questionnaire asks about your symptoms as well as your ability to perform certain activities.

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

Lower Extremity Functional Survey(LEFS) page2

Today, do you or would you have difficulty with the following items (*If you did not have the opportunity to perform an activity, make your best estimate on which response would be the most accurate. Please answer based on your ability regardless of how you perform the task*):

(Circle one number on each line)

	Unable to Perform	Extremely Difficult	Moderate Difficulty	Little Difficulty	No Difficulty
a. Any of your usual work or school activities.	4	3	2	1	0
b. Your usual hobbies, recreational or sporting activities.	4	3	2	1	0
c. Getting into or out of the bath; or bathing	4	3	2	1	0
d. Walking between rooms.	4	3	2	1	0
e. Putting on socks and shoes.	4	3	2	1	0
f. Squatting.	4	3	2	1	0
g. Lifting an object. eg) bag of groceries.	4	3	2	1	0
h. Performing light activities around your home.	4	3	2	1	0
i. Performing heavy activities around your home.	4	3	2	1	0
j. Getting into or out of your car.	4	3	2	1	0
k. Walking 2 blocks.	4	3	2	1	0
l. Walking a mile.	4	3	2	1	0
m. Going up or down a flight of stairs (about 10 stairs).	4	3	2	1	0
n. Standing for 1 hour.	4	3	2	1	0
o. Sitting for 1 hour.	4	3	2	1	0
p. Running on even ground.	4	3	2	1	0
q. Running on uneven ground.	4	3	2	1	0
r. Making sharp turns while running fast.	4	3	2	1	0
s. Hopping.	4	3	2	1	0
t. Rolling over in bed.	4	3	2	1	0
u. Caring for dependents.	4	3	2	1	0
v. Toileting.	4	3	2	1	0
w. Performing yard work.	4	3	2	1	0
x. Getting into or out of a chair.	4	3	2	1	0
y. Kneeling.	4	3	2	1	0

Column Totals:

Office use only:

Score: /100