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

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.

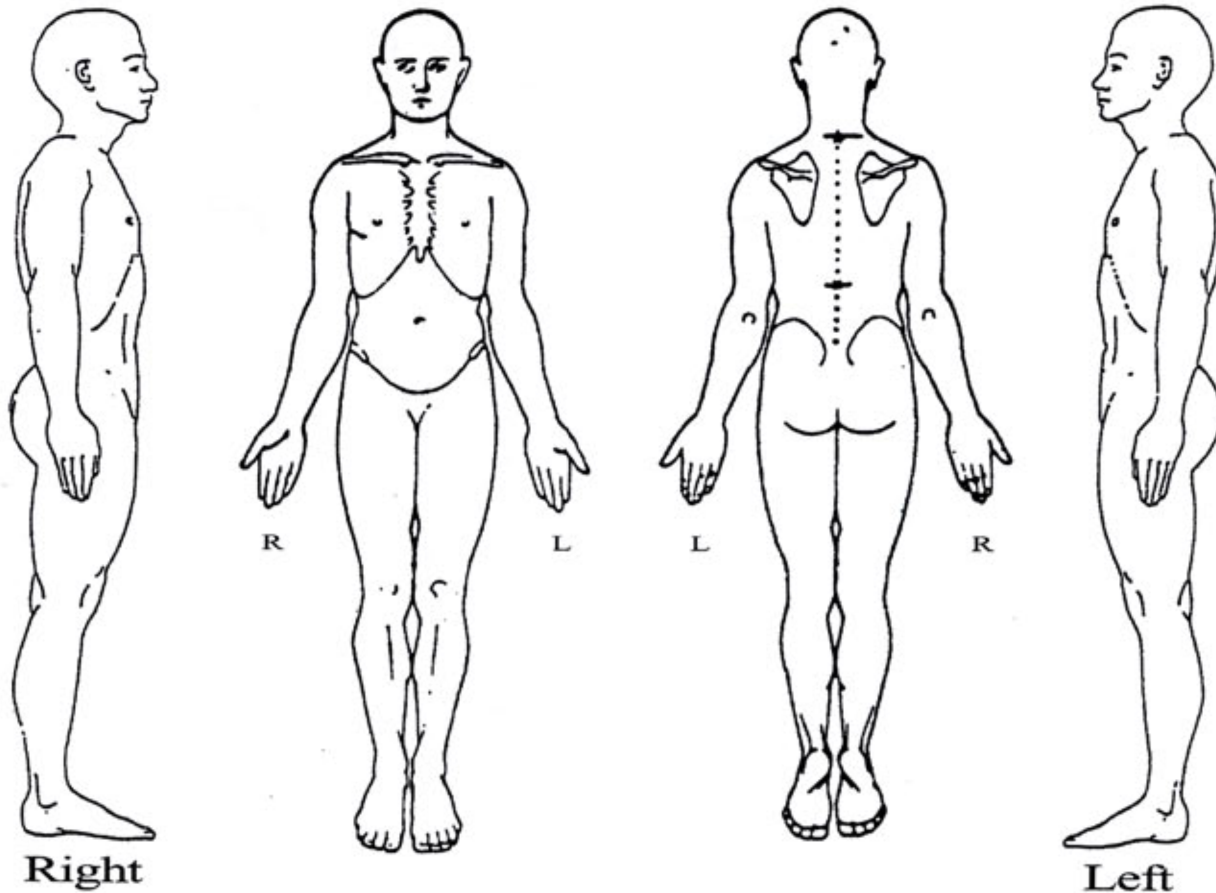
West Windsor Plainsboro Physical Therapy Center

Neck (and upper back) Functional Survey

Name:_______________________________ Date:________________________

This questionnaire asks about your symptoms as well as your ability to perform certain activities. It was designed to enable us to understand how much your pain effects your ability to manage everyday activities.

Please shade the area of your pain.



Please circle <u>**only one number**</u> 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

Neck Functional Survey (page 2)

Name:______________________________Date:_________________

Please answer ***every section*** by marking the [] next to the ***one*** most appropriate response. If you did not have the opportunity to perform an activity, make your *best estimate* on which response would be the most accurate. Answer based on your ability regardless of how you perform the task. Please do not insert your own answers.

Section 1: Pain Intensity

[] I can tolerate the pain without using medication.
[] The pain is bad, but I manage without medication.
[] Medication gives me complete relief from pain.
[] Medication gives me moderate relief from pain.
[] Medication gives me little relief from pain.
[] Medication has no effect and I do not use it.

Section 2: Personal Care

[] I can look after myself without causing extra pain.
[] I can look after myself normally but it causes extra pain.
[] It is painful to look after myself and I am slow and careful.
[] I need some help but manage most of my personal care.
[] I need help everyday in most aspects of self care.
[] I do not get dressed, wash with difficulty, and stay in bed.

Section 3: Lifting

[] I can lift heavy weights without extra pain.
[] I can lift heavy weights but it gives extra pain.
[] Pain prevents lifting heavy weights from the floor, but I can manage if they are conveniently positioned higher.
[] Pain prevents me from lifting heavy weights, but I can manage light- to medium weights if they are conveniently positioned higher.
[] I can only lift very light weights.
[] I cannot lift or carry anything at all.

Section 4: Headaches

[] I have no headaches.
[] I have slight headaches which come infrequently.
[] I have moderate headaches which come infrequently.
[] I have moderate headaches which come frequently.
[] I have severe headaches which come frequently.
[] I have headaches almost all the time.

Section 5: Sitting / Reading

[] I can sit/read in any chair as long as I like.
[] I can only sit/read in my favorite chair as long as I like.
[] Pain prevents me from sitting/reading more than 1 hour.
[] Pain prevents me from sitting/reading more than ½ hour.
[] Pain prevents me from sitting/reading more than 10 minutes.
[] Pain prevents me from sitting/reading at all.

Section 6: Concentration

[] I can concentrate fully when I want to with no difficulty.
[] I can concentrate fully when I want to with slight difficulty.
[] I have a fair degree of difficulty concentrating when I want to.
[] I have a lot of difficulty concentrating when I want to.
[] I have a great deal of difficulty concentrating when I want to.
[] I cannot concentrate at all.

Section 7: Sleeping

[] Pain does not prevent me from sleeping well.
[] I can sleep well only by using medicine.
[] Even with medicine, I have less than 6 hours sleep.
[] Even with medicine, I have less than 4 hours sleep.
[] Even with medicine, I have less than 2 hours sleep.
[] Pain prevents me from sleeping at all.

Section 8: Sex Life

[] My sex life is normal and causes no extra pain.
[] My sex life is normal but causes some extra pain.
[] My sex life is nearly normal but is very painful.
[] My sex life is severely restricted by pain.
[] My sex life is nearly absent because of pain.
[] Pain prevents any sex life at all.

Section 9: Social Life

[] My social life is normal and gives me no extra pain.
[] My social life is normal but increases the degree of pain.
[] Pain has no significant effect apart from limiting more energetic interests such as dancing.
[] Pain has restricted my social life and I do not go out often.
[] Pain has restricted my social life to my home.
[] I have no social life because of pain.

Section 10: Traveling

[] I can travel anywhere without extra pain.
[] I can travel anywhere but it gives me extra pain.
[] Pain is bad but I manage trips over 2 hours.
[] Pain restricts me to trips of less than 1 hour.
[] Pain restricts me to short trips under 30 minutes.
[] Pain prevents me from traveling except to the doctor or hospital.

Office use only:

Functional Index Score___________%