CARUSO
PHYSICAL THERAPY
AND NUTRITION, LLC

# Medical Information Sheet

Name:_____ Date: _____

Age: ____ Gender:_____ Height: ____ Weight: ____ Dominant hand: R L

Occupation: _____ Presently working: Y N

Reason for being seen today: _____

Date of Onset: _____ Involved side: R L Both

Describe any previous problems with this area: _____

Physician: _____ Diagnosis: _____

Medical Tests: X-Ray__ CAT Scan__ Bone Scan__ MRI__ EMG__ Nerve Conduction__ Anthrogram__
Other_____ Results_____

Did you have surgery? Y N Date:_____

Did you use: Cast___ Splint___ Brace___ Date Applied:_____ Date Removed:_____

Have you ever been diagnosed with any of the following conditions?

| | | |
|---|---|---|
| Y N Asthma | Y N Headaches | Y N Kidney Problems |
| Y N Cancer | Y N Heart Attack | Y N Low Blood Pressure |
| Y N Chest Pain | Y N Heart Disease | Y N Osteoporosis/ Osteopenia |
| Y N Depression | Y N Hepatitis | Y N Osteoarthritis |
| Y N Diabetes Type I or II | Y N Hernia | Y N Pacemaker/Defib |
| Y N Dizziness/ Vertigo | Y N High Blood Pressure | Y N Currently Pregnant |
| Y N Emphysema/Bronchitis | Y N HIV | Y N Seizures |
| Y N Fainting | Y N Joint Replacements | Y N Stroke |

If you are 65 or older, have you fallen in the past 12 months? Y N If yes, how many times? ____

Did your fall result in an injury(s)? Please explain briefly._____

Please list all current medications: _____

_____

Indicate any activities that you have difficulty completing (walking, sitting, running, climbing stairs)_____

_____

What goals do you hope to accomplish with Physical Therapy? _____

Indicate the intensity of your pain at rest: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Indicate the intensity of your pain with movement: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Is your pain: Constant____ Intermittent___

Activities that increase pain:_____

Activities that decrease pain:_____

Nutrition is a key component of injury rehabilitation that is often overlooked by all. In fact, a well designed nutrition plan can speed up the healing process. Poor quality dietary habits can actually impede your recovery. Even if you think you have good habits you should make sure you are fueling yourself for the best recovery.

How important is it for you to make this change in your nutritional health/intake? Low 1 2 3 4 5 High

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# New Patient Referral and Insurance Verification Form

Today's Date: _____ Prior Patient: Y N

How did you hear about our practice? Physician: Dr._____, Internet: _____,
Family/Friend:_____, Advertising:_____, Insurance:_____, Other:_____.

Patient Information:
Name: _____
Address: _____ Birth date: _____
_____ Email: _____
Home Phone: _____ Cell: _____

Referring Physician: _____ Ref Phys Phone: _____
When is your next doctor appointment? _____

Primary Physician: _____ Prim Phys Phone: _____
When is your next doctor appointment? _____

Emergency Contact Information:
Name: _____
Phone Number: _____ Relationship: _____

Injury/Illness Information:
Diagnosis: _____
Date of Injury: _____ Work Related? Y N State ___ Are you working? Y N Full or Light Duty
Auto Related? Y N State ____ School Sports Injury? Y N School _____

If patient under the age of 18, please fill out the Guarantor information below:
Guarantor Name: _____ Guar. Phone: _____
Address: _____ Relationship: _____

****REMEMBER: You need a REFERRAL (different from a prescription) from their Primary Care Physician specific to Caruso Physical Therapy and Nutrition, LLC if your insurance plan requires one.****

Insured Information (If different from patient)
Insured/ Sponsor Name:_____
Employer or Military Branch:_____
Relationship:_____ Insured DOB:_____

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**Notice of Patient Information Practices**

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

**Caruso Physical Therapy and Nutrition LEGAL DUTY**

Caruso Physical Therapy and Nutrition is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

**USES AND DISCLOSURES OF HEALTH INFORMATION**

Caruso Physical Therapy and Nutrition uses your personal health information primarily for treatment, obtaining payment for treatment, conduction internal administrative activities, and evaluation the quality of care that we provide. For example, Caruso Physical Therapy and Nutrition may use your personal health information to contact you to provide appointment reminders, or information about treatment alternative or other health related benefits that could be of interest to you.

Caruso Physical Therapy and Nutrition may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, and for emergencies. We may provide de-identified information for research studies. We also provide information when required by law.

In any other situations, Caruso Physical Therapy and Nutrition's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason you may later revoke that authorization to stop future disclosures at any time.

Caruso Physical Therapy and Nutrition may change its policy at any time. When changes are made, a new notice of information practices will be posted in a common area of our clinic. You may also request an update copy of our Notice of Information Practices at any time.

**PATIENTS' INDIVIDUAL RIGHTS**

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. Caruso Physical Therapy and Nutrition will consider all such requests on a case by case basis, but the company is not legally required to accept them.

**CONCERNS AND COMPLAINTS**

If you are concerned that Caruso Physical Therapy and Nutrition may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, you may send a written complaint to the US Department of Health and Human Services.

# Patient Information Consent Form

I have read and fully understand Caruso Physical Therapy and Nutrition's Notice of Information Practices. I understand that Caruso Physical Therapy and Nutrition may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluate the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the company in writing. I also understand that Caruso Physical Therapy and Nutrition will consider requests for restriction on a case by case basis, but does not have to agree to request for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Caruso Physical Therapy and Nutrition's and Notice of Information Practices. I understand that I retain the right revoke to this consent by notifying the company in writing at any time.

# Insurance Information

As a courtesy to our patients, we will verify and file your insurance claim, **HOWEVER**, we cannot guarantee payment by your insurance company. It is your responsibility to read your policy manual as it pertains to physical therapy coverage. Many insurance companies have stipulations, such as usual and customary rates (UCR), written referral requirements, limitation to number of therapy visits, limitations to reimbursable amounts per session, deductibles, coinsurance portions, copayments, limits on supplies, etc. Such stipulations should be indicated in your policy manual, if not, we recommend that you contact your insurance company directly.

YOU ARE RESPONSIBLE FOR AMOUNTS NOT COVERED BY YOUR INSURANCE. We have an agreement with YOU, not your insurance company, for receipt of payment. Please be aware of this and plan to make payments accordingly. Benefits will be verified for Workers' Compensation and Automobile Accident Claims, however, this does not guarantee payment. In the event of denial or exhaustion of benefits, this account becomes YOUR RESPONSIBILITY.

_____

Patient Name

_____

Signature

_____

Date

**FINANCIAL RESPONSIBILITY/ ASSIGNMENT OF BENEFITS**

Thank you for choosing Caruso Physical Therapy and Nutrition, LLC for your rehabilitation needs. As healthcare benefit and coverage options continue to increase in complexity, we have developed financial policies to assist you in understanding your responsibilities as a patient. This form is intended to communicate your financial responsibilities as a patient.

**FINANCIAL RESPONSIBILITY**

I understand that my insurance contract is between me, my employer and the insurance company and that Caruso Physical Therapy and Nutrition, LLC is not a party to that contract. I understand that Caruso Physical Therapy and Nutrition, LLC will contact my insurance company (including Medicare) to verify my benefits, but that it is my responsibility to understand what is covered and required under my policy. I acknowledge that providing accurate insurance and other information is critical to determining patient eligibility and benefits available.

I understand that Caruso Physical Therapy and Nutrition, LLC will bill my insurance carrier (including Medicare) for services rendered upon verification of coverage by my insurance company. I understand that verification of benefits is not a guarantee of payment and my financial responsibility is subject to change. If my insurance company fails to render payment for services rendered, I hereby personally guarantee payment for medical care and services rendered. If my insurance company does not remit payments, including if I am denied benefits under workers compensation, I understand that I will be responsible for the balance due in full.

I understand that I am responsible for paying my co-payments; co-insurance (including co-insurance from Medicare) and deductibles at the time of service which I acknowledge may be an estimate at that time. Further, I understand that laws and insurance company contracts prevent Caruso Physical Therapy and Nutrition, LLC from adjusting, writing off or waiving co-payments, co-insurance (including co-insurance from Medicare) and deductibles.

Pursuant to the assignment of benefits herein; I hereby request that my insurance carrier make payment directly to Caruso Physical Therapy and Nutrition, LLC for all services rendered by this facility. If my current policy prohibits direct payment to Caruso Physical Therapy and Nutrition, I hereby instruct and direct my insurance carrier to make the check out in my name but send the check to: Caruso Physical Therapy and Nutrition, LLC 1278 Yardville-Allentown Road Suite 3 Allentown, NJ 08501. If my insurance carrier makes payments to me I agree to immediately pay over these funds to Caruso Physical Therapy and Nutrition, LLC. I also authorize Caruso Physical Therapy and Nutrition, LLC, to deposit check received on my account when made out to me.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

**ASSIGNMENT OF BENEFITS**

I, the undersigned, hereby assign to Caruso Physical Therapy and Nutrition, LLC (hereinafter "Assignee") any and all rights, claims, benefits, and causes of action for personal injury protection benefits and medical payment benefits available to me under the policy affording coverage to me for any and all treatment, services, and medical claims resulting from an automobile accident that occurred. This is to act as an assignment of my rights and benefits to the extent of Assignee's services provided. In the event that I do not have insurance coverage, I understand that I remain personally responsible for payment of services rendered including all costs of collection, including attorney's fees and costs.

**ASSIGNMENT OF CAUSE OF ACTION**

I hereby assign by this instrument all rights and causes of action in tort, in contract and the laws of New Jersey against the personal injury protection carrier for its failure to pay for services rendered unto me by Assignee in relation to my accident that occurred.

Please call our Office if you have any questions on your account or if you are unable to pay your balance in full they will be able to discuss payment arrangements with you. The number is 609-738-3143.

_____

Print Name of Patient

_____ _____

Print Name of Guardian (if applicable) Relationship to Patient (if applicable

_____ _____

Patient/Guardian Signature Date

Pelvic Floor Questionnaire

Patient Name _____ Date _____

Please fill in the following questionnaire to the best of your ability. The therapist will review the answers with you at you appointment.

**History**

Number of pregnancies _____

Number of vaginal deliveries_____

Birth weight of largest baby _____

Number of cesarean deliveries _____

Did you have any trouble healing after delivery YES NO

Do you have a history of sexual abuse or trauma YES NO

Are you having regular periods/menstrual cycles YES NO

Do you have frequent urinary tract infections YES NO

**Pain**

Do you have pain with:

Sexual Intercourse YES NO

Pelvic Exam YES NO

Tampon Use YES NO

Back, leg, groin, abdominal pain YES NO

**Test Results**

Urodynamics Test YES NO Results_____

Cystoscope Test YES NO Results _____

Urine Test YES NO Results _____

Bowel Test YES NO Results_____

**Bladder Symptoms**

Do you lose urine when you:

Cough/sneeze/laugh YES NO

Lift/exercise/dance/jump YES NO

On the way to the bathroom YES NO

Have a strong urge to urinate YES NO

Hear running water YES NO

Other_____

Do you wet the bed? YES NO

Have burning/pain with urination YES NO

Difficulty starting a stream of urine YES NO

Feel unable to empty bladder fully YES NO

Have a "falling out" feeling YES NO

Have pain with a full bladder YES NO

Urinate more than 7 times a day YES NO

**Bowel Symptoms**

Strain to have a bowel movement YES NO

Leak/stain feces YES NO

Include fiber in your diet YES NO

Have diarrhea often YES NO

Take laxatives/enema regularly YES NO

Leak gas by accident YES NO

Have pain with bowel movement YES NO

Have a very strong urge to move your bowels YES NO

How often do you move your bowels per day/week? _____

Most common stool consistency

_____liquid _____soft _____firm _____pellets _____other _____