



WELCOME

Please take a few minutes to answer the following questions so we can better assist you with your health care needs.

PATIENT INFORMATION

Date _____ Soc. Sec. # _____ Birth Date _____
Name _____
Last Name First Name Initial
Address _____ Home Phone _____
City _____ State _____ Zip _____
Sex: M F Minor Single Married Divorced Widowed
Employer _____ Business Phone _____
Business Address _____ Occupation _____
Who should we thank for referring you? _____
In case of emergency, who should we contact? _____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial
Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____
Address _____ Home Phone _____
City _____ State _____ Zip _____
Responsible Party Employed By _____ Business Phone _____
Business Address _____ Occupation _____
Insurance Company _____
Insurance Company Address _____
Subscriber I.D. # _____ Group # _____

ADDITIONAL INSURANCE (IF APPLICABLE)

Person Responsible for Account _____
Last Name First Name Initial
Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____
Address _____ Home Phone _____
City _____ State _____ Zip _____
Responsible Party Employed By _____ Business Phone _____
Business Address _____ Occupation _____
Insurance Company _____
Insurance Company Address _____
Subscriber I.D. # _____ Group # _____

REASON FOR VISIT

Please list your reason/symptoms for today's visit: _____

Date symptoms appeared: ___ / ___ / ___

Is this condition due to an: Auto accident Work Injury Other Accident Unknown cause Illness

Are the symptoms: Improving Getting worse About the same Intermittent (come & go)

Check all activities that aggravate your condition: Standing Walking Sitting Lying down Bending
Lifting Twisting Coughing Other _____

Have you had these symptoms before? No Yes If yes, when: ___ / ___ / ___

Have you ever seen another Physical/Occupational Therapist for this condition: No Yes
If yes, whom: _____ when: ___ / ___ / ___

Are you presently receiving Physical/Occupational Therapy services at home? No Yes

Do you have any current or past health conditions that we should be aware of: _____

REFERRAL PHYSICIAN INFORMATION

Who is the Doctor that referred you for therapy: Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: () _____ Specialty: _____ Date consulted: ___ / ___ / ___

PRIMARY CARE PHYSICIAN INFORMATION

Who is your Primary Care Physician: Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: () _____ Specialty: _____ Date consulted: ___ / ___ / ___

ATTORNEY INFORMATION (IF APPLICABLE)

Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: () _____ Date consulted: ___ / ___ / ___

ASSIGNMENT AND RELEASE

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize payment from my insurance carrier directly to this office with the understanding that all monies be credited to my account (A copy of this assignment is as valid as the original). I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also authorize the release of any and all information, facts and particulars regarding my physical condition and/or treatments to its authorized agent and/or assigns as it may deem necessary for continuation of my medical care and/or processing and collecting any and all associated costs.

I also understand that if I suspend or terminated my care and treatment, the fees for professional services rendered me will be immediately due and payable. In the event of default I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection.

I have received a copy of the Patient Information Brochure which contains rules and regulations to be followed and the financial policy of D&H Therapy.

Signature of Responsible Party _____ Date _____

D & H THERAPY

PATIENT INFORMATION BROCHURE

SCOPE OF SERVICES RENDERED

Our medical care is restricted to the portion of medicine referred to as the Specialty of Rehabilitation; more specifically, Physical, Occupational and Speech-Language Therapy.

Physical Therapists are unique hands on specialists who evaluate the patient's physical abilities and design an individualized program of treatment through the utilization of therapeutic techniques, modalities or "tools" and education.

Occupational Therapists evaluate skills necessary to function in one's daily occupational tasks, such as work, homemaking, school, or play. The skills required to perform these tasks include upper extremity functioning, strength, coordination, motor and sensory functions, perception, cognition, fine motor, activity tolerance and psychosocial skills. Highly individualized programs are designed to improve activities of daily living through exercise, developmental sequencing, activity simulation and implementation of adaptive equipment and/or bracing depending on age and the nature of the disability.

OFFICE HOURS

Patients are seen by appointment only in the following locations during the below outlined hours of operation. However on occasion there may be a need to schedule an appointment during an alternate time to meet the need of a client or accommodate a clinician schedule change.

Pawtucket Office-Main Office
100 Smithfield Avenue
Pawtucket, RI 02860
401-725-9666

Monday: 8:00 a.m. to 5:00 p.m.
Tuesday: 8:00 a.m. to 5:00 p.m.
Wednesday: 8:00 a.m. to 5:00 p.m.
Thursday: By appointment*
Friday: 8:00 a.m. to 5:00 p.m.

Pool Program at EPOCH on the East Side

Tuesday: 12:15 p.m. to 1:15 p.m.
Friday: 12:15 p.m. to 1:15 p.m.

Lincoln Office-Satellite Office
3 Wake Robin Road
Lincoln, RI 02865
401-333-1747

Monday: 7:00 a.m. to 7:30 p.m.
Tuesday: 8:00 a.m. to 8:00 p.m.
Wednesday: 7:00 a.m. to 6:00 p.m.
Thursday: 8:00 a.m. to 8:00 p.m.
Friday: 7:00 a.m. to 2:30 p.m.

Greenville Office-Satellite Office
400 Putnam Pike
Urgent Care
Smithfield, RI 02917
401-233-3977

Monday: 7:00 a.m. to 3:00 p.m.
Tuesday: By appointment *
Wednesday: 7:00 a.m. to 3:00 p.m.
Thursday: By appointment *
Friday: 7:00 a.m. to 3:00 p.m.

Cumberland Office-Satellite Office
2140 Mendon Road
Urgent Care
Cumberland, RI 02864
401-475-3000 ext. 128

Monday: 8:00 p.m. to 4:00 p.m.
Tuesday: 10:00 a.m. to 7:00 p.m.
Wednesday: 8:00 p.m. to 4:00 p.m.
Thursday: 10:00 a.m. to 7:00 p.m.
Friday: 8:00 a.m. to 1:30 p.m.

EPOCH on the East Side
One Butler Avenue
RI 02906
401-273-5031

Monday: By appointment *
Tuesday: By appointment *, Pool 12:15 p.m. to 1:15 p.m. Providence,
Wednesday: By appointment *
Thursday: By appointment *
Friday: By appointment *, Pool 12:15 p.m. to 1:15 p.m.

Pool Program at Lincoln Place

Monday: 5:00 p.m. to 6:00 p.m.
Wednesday: 5:00 p.m. to 6:00 p.m.

***Alternate appointments available upon request**

EMERGENCIES:

In the event of an emergency please call the office in which you receive therapy. If that office is not open, then please call the main office in Pawtucket to speak to someone directly. Any calls made after business hours will be forwarded to an answering machine for you to leave a message and we will make every attempt to return your call at the start of the next business day.

If you feel that the problem requires an immediate response please contact your referring physician immediately and he will appropriately advise you.

TIMELINESS:

We make a sincere attempt to adhere to the schedule as much as possible. Occasionally, there are emergency situations which arise where the therapist may be detained. It is important for you to be on time for all your scheduled appointments. It is not fair to other individuals who are on time to be delayed because of those who are late. If you are late, there is no guarantee that you will receive your full treatment. If you are greater than 15 minutes late it is possible that no treatment will be given for that day.

CANCELLATIONS/NO SHOWS:

The following are our policies regarding cancellations and no-shows. We take this subject seriously because it can make the difference between whether you succeed in your treatment or not. Generally your referring doctor and/or your therapist have recommended 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 your therapist's instructions and we will be able to help you achieve your goals in treatment.

1. 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 that you get in the full prescribed number of treatments that week whenever possible. (In some cases, this may not work.)
2. There is a \$25.00 charge for a cancellation without proper notice. This charge will not be covered by insurance, but will have to be paid by you personally.
3. Missed appointments are part of your medical record. As a result they are forwarded on to case managers, physicians, attorneys, and insurance carriers. At times missed appointments could jeopardize your claim.
4. Please understand that your pain will probably increase and decrease as your course of treatment progresses and before you reach maximum improvement. If you're feeling worse and think the treatment is not working or, if you're feeling better and think it's a great day for the beach, neither of these conditions is a legitimate reason not to come. If you're in pain, come in. If you're pain free, now is the time that we can begin a progressive correction of the underlying cause of your problem and education to prevent re-injury, etc.

When you don't show as scheduled, three people are hurt: You because you don't get the treatment you need as recommended by the doctor and/or PT; the therapist who now has a space in their schedule, since time was reserved for you; and another patient who could have been scheduled for treatment if you had given proper notice.

Any individual who does not show and does not call for three consecutive visits or has three unacceptable cancellations will automatically be discharged back to their referring physician. If there are extenuating circumstances, please advise the office at the time of cancellation.

SMOKING:

Smoking is prohibited in all areas of our building. If you have to smoke, inform the receptionist that you will take a short walk outside for a smoke. She will reserve your place for you.

MEDICAL RECORDS:

Your medical records are held in strict confidence. Information is provided to your referring physician, case managers, and third party insurance company in the form of initial evaluations, re-check visits, and discharge summaries. Upon your initial visit you will be signing an authorization which will allow us to release this information. If information about your condition needs to be provided to another insurance company or your attorney, they must request the information in writing and provide us with the written authorization signed by you to do so. Since the assimilation and organization of pertinent medical information takes time, we must charge for this process. The charge varies with the complexity of the record.

WORKERS COMPENSATION:

Any patient that is covered under workers compensation is asked to provide personal health insurance information. In the event that your workers compensation claim is denied we will then submit your bills to your personal health insurance. The time period that we will have to rebill your account is a limited window, therefore we ask that you submit your insurance to us on your first visit. Without this information we are unable to bill your insurance carrier and you will be liable for all denied charges.

Please advise the front desk of any change of address, phone number, marital status, insurance, etc. that may have occurred since your last visit.

I have received a copy of the Patient Information Brochure.

Signature

Date

D & H Therapy Associates, LLC

Medical History Questionnaire

Name: _____

Date: _____

Have you had or do you have any of the following conditions?

Yes No

- Heart attack
- Heart palpitations
- Angina
- Chest pain with exertion
- Heart murmur
- Abnormal heart rate
- Pacemaker
- Any other heart problems
- High blood pressure
- Diabetes
- Low blood sugar
- Shortness of breath
- Asthma or allergies
- Other lung problems
- Heartburn, stomach or intestinal upset

Yes No

- History of ulcers
- Cancer
- Chance of pregnancy
- Loss of appetite
- Night sweats or fever
- History of neck or back pain
- Bowel or bladder problems
- Thyroid problems
- Osteoporosis
- Headaches
- Frequent sprains or strains
- Joint pain or swelling
- History of fractures
- Metal implants/plates/screws
- History of trauma
- History of seizure/epilepsy

Please list all medications that you are currently taking, including over the counter medications.

Please list all surgeries and dates:

Are there any other medical conditions that we should know about?

Signature: _____

Date: _____

Therapist: _____

Date: _____

FINANCIAL AGREEMENT

HEALTH INSURANCE

We would like to take a moment to welcome you to our office and assure you that you will receive the very best care available for your condition. In order to familiarize you with the financial policy of this office, we would like to explain how your medical bills will be handled.

EXPLANATION OF INSURANCE COVERAGE

Most insurance policies cover physical/occupational therapy, but this office makes no presentation that yours does. Insurance policies can differ greatly in terms of deductible and percentage of coverage for therapy service. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance company(ies) in a timely manner.

PAYMENT ARRANGEMENTS

We require that you pay _____% or _____ per visit of your charges on a _____ basis. Any remaining balance of unpaid charges will be billed to you. Your bill must be paid within 30 days of the statement date. Any unpaid balances will be considered past due 31 days following the 1st statement date. An interest charge of **1%** per month may be applied to your past due balance.

ASSIGNMENT OF BENEFITS

Attached is an "Assignment of Benefits" form which we would like you to sign. This form instructs your insurance company to send their payments directly to this office. Please sign all copies of this form. If your insurance carrier sends you payment for services incurred in this office, you shall send or bring the full payment to our office immediately upon receipt.

RELEASE OF INFORMATION

If your insurance company requires medical reports to document your treatment and progress, your signature below authorized the release of medical information necessary to process your claim.

VOLUNTARY TERMINATION OF CARE

If you suspend or terminate your care at any time, your portion of all charges for professional services are immediately due and payable to this office. All services rendered by this office are charged directly to you, and you, ultimately, will be personally responsible for payments, regardless of your insurance coverage.

We hope that this answers any questions you might have concerning the financial policies of this office. Once again, we welcome you to our office and will be glad to answer any further questions you might have.

I have read and agree to the above.

Patient's Signature

Date

**ASSIGNMENT AND INSTRUCTION FOR
DIRECT PAYMENT TO HEALTH PROVIDER**

Patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance Company: _____

Insured's ID#: _____ Claim or Group #: _____

SS# or Drivers License #: _____

I hereby instruct the above named Insurance Company to pay by check, made out to and mailed directly to:

**D & H Therapy Associates
100 Smithfield Avenue
Pawtucket, RI 02860**

For professional or medical expense allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy.

A photocopy of this Assignment shall be considered effective and valid as the original.

I also authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance.

Dated at _____ County, this _____ day of _____ 20__

Patient or Authorized Person's Signature **Witness** _____ **Signature of**

If other than patient: Policy Holder Parent Legal Guardian

Other(explain): _____

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.

Introduction

At D&H Therapy we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003 and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record

Each time you are scheduled for a visit at D&H Therapy, a record of this visit is made. Typically, this record contains your referral, diagnosis, evaluation, symptoms, test results, record of treatment, plan of care, progress notes, attendance and participation, insurance authorization, and billing related information. This information serves as a:

- Basis for planning care and intervention
- Communication among health care providers who contribute to your care
- Legal document describing the care you received
- Means by which you or the third party payer can verify that services billed were actually provided
- A source of data for medical research
- A tool in educating health care professionals
- A source of information for public health officials charged with improving healthcare
- A source of data for planning and program development
- 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 and make informed decisions when authorizing disclosure to others

Our Responsibilities

We are required by law to maintain the privacy of protected health information, and provide you a description of our privacy practices and legal duties with respect to information we collect and maintain about you.

We are required to abide by the terms of this Notice. We reserve the right to change the terms of the Notice at any time. Any changes will be effective for all protected health information we already have about you as well as any future information we may receive. The current Notice will be posted in the clinic and include the effective date. In addition, each time you are referred to D&H Therapy for services, we will provide you a copy of the current Notice in effect.

For More Information

We have designated a Privacy Officer to answer your questions about our privacy practices and to ensure that we comply with applicable laws and regulations. The Privacy Officer will also take your complaints and can give you information about how to file a complaint.

Our Privacy Officer is Kim M. Havunen. You can contact the Privacy Officer at (401) 725-9666.

Use and Disclosures

The following describes the way we may use your protected health information to carry out treatment, payment, and health care operations.

We may use medical information in your record to provide **treatment** to you. We will disclose information in your record to your referring physician. We may disclose medical information to other health professionals involved in your care, those assisting in coverage in our practice and subsequent health care providers to assist them in your treatment. For example, a therapist treating you for a back pain may recommend further testing as a result of poor progress. Different providers involved in your care may share information about you in order to coordinate the best possible care you may need.

We may use or disclose information from your record to bill and collect **payment** from you, your insurance company or a third party payer for the services you receive. For example, we may submit your diagnosis with a health insurance claim in order to demonstrate to the insurer that the service should be covered.

We may use or disclose information from your record to allow “**health care operations.**” These operations include activities like reviewing records to see how care can be improved, contacting you with information about treatment alternatives, and coordinating care with other providers. For example, we may use information in your record to train our staff about your condition and treatment.

We may also use and disclose health information:

- To **notify** you of receipt of your referral for service
- To **schedule** your initial appointment for service
- To **remind** you or **confirm** a scheduled appointment for service
- To **notify** you of alternative treatment options
- To **notify** you of insurance benefits or limitations to benefits
- To **assess** your satisfaction of services
- To **conduct** training programs
- To **review** competence of health care professionals
- To **communicate** new programs developed

There are some services provided in our organization through contracts with **business associates.** For example, we use transcription services and computer hardware and/or software consultants. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked them to do. To protect your health information, we require the business associate to appropriately safeguard your information.

Our therapists, using their best judgment, may **communicate** with family member, other relative, close personal friend or any other person you identify who may be involved with your medical care or who helps pay for your care.

We may disclose information regarding services you are seeking or receiving during our **notification** to you of a referral received, scheduled appointment or insurance communication by leaving a message at your home, on an answering machine or on voicemail as a means of communication.

We may disclose information to researchers when the **research** proposal has been reviewed and approved by the organizations partners and provides protocols to ensure the privacy of your health information.

We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to **workers compensation.**

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

In certain circumstances, we are **required by law** to use and disclose health information to the following types of entities, including but not limited to:

- Public Health Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Food and Drug Administration
- Military Command Authorities
- Health Oversight Authorities
- National Security and Intelligence Agencies
- Protective Services for the President or Others
- Department of Health and Human Services, if requested, to prove that we are complying with regulations that safeguard your health information.

Some states have separate privacy laws that may apply additional legal requirements. If the State laws are more stringent than the Federal privacy laws, the State laws will preempt the Federal law.

Your rights

Although your health record is the physical property of D&H Therapy you have the Right to:

You may ask us to **restrict** the use and disclosure of certain information in your record that otherwise would be allowed for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone else who is involved in your care or payment for your care. Your request must be in writing. However, we do not have to agree to these restrictions.

You have a right to receive **confidential communications** from us in a certain way or at a certain location. For example, if you want to receive bills and other information at an alternative address. D&H Therapy will grant requests for confidential communication at alternative locations or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services rendered by the facility and related correspondence regarding payment for services. Please realize, we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other mean sat another location.

You have a right to **inspect and obtain a copy** of the medical information in your record. This may be subject to certain limitations and fees. Your request must be in writing.

If you believe information in your record is inaccurate or incomplete, you may request **amendment** of the information for as long as the information is kept by our office. You must submit sufficient information to support your request for amendment. Your request must be in writing. We have the right to deny your request and if this occurs, you will be notified of the reason for the denial

You have the right to request an **accounting of disclosures** made by us. This is a list of certain disclosures we make of your medical information for purposes other than treatment, payment or health care operations.

You have the right to complain to us about our privacy practices (including the actions of our staff with respect to the privacy of your health information). You have the right to complain to the Secretary of the Department of Health and Human Services about our privacy practices. You will not face retaliation from us for making **complaints**.

You have the right to a **paper copy** of this notice. You may ask us to give you a copy of this notice at any time.

Except as described in this Notice, we may not make any use or disclosure of information from your record unless you give your written authorization. You may revoke an authorization in writing at any time, but this will not affect any use or disclosure made by us before the revocation. In addition, if the authorization was obtained as a condition of obtaining insurance coverage, the insurer may have the right to contest the policy or a claim under the policy even if you revoke the authorization.

To exercise any of your rights, please obtain the required forms from the front desk or the Privacy Officer.