



# WELCOME!

Today's Date: \_\_\_\_\_

## PATIENT INFORMATION

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_  
Address: (Street) \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_  
Male/Female (circle one)      Date of Birth: \_\_\_\_\_      Social Security Number: \_\_\_\_\_  
Phone: Home \_\_\_\_\_ Message OK?  Yes  No Cell \_\_\_\_\_ Message OK?  Yes  No  
E-mail Address \_\_\_\_\_  
Emergency contact: Name \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Phone \_\_\_\_\_ Message OK?  Yes  No  
Work Address: \_\_\_\_\_ Occupation \_\_\_\_\_

## INSURANCE INFORMATION

Name of Insurance #1: \_\_\_\_\_ Subscriber ID#: \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Soc. Sec. # \_\_\_\_\_ Birth date \_\_\_\_\_ Group#: \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Phone \_\_\_\_\_  
Work Address: \_\_\_\_\_  
  
Name of Insurance #2: \_\_\_\_\_ Subscriber ID#/Claim#: \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Soc. Sec. # \_\_\_\_\_ Birth date \_\_\_\_\_ Group#: \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Phone \_\_\_\_\_  
Work Address: \_\_\_\_\_

## PHYSICIAN INFORMATION

Referring Physician: Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: ( ) \_\_\_\_\_ Specialty: \_\_\_\_\_ Date consulted: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
  
Primary Care Physician: Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: ( ) \_\_\_\_\_ Specialty: \_\_\_\_\_ Date consulted: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## ATTORNEY INFORMATION (If Applicable)

Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: ( ) \_\_\_\_\_ Date consulted: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Are you presently receiving **any** kind of services or help at home that your insurance is paying for?  No  Yes

Who should we thank for Referring You? \_\_\_\_\_ Client/Rep Initials \_\_\_\_\_

**CONSENT, ACKNOWLEDGEMENT, AUTHORIZATION AND ASSIGNMENT TO SERVICE INTERVENTION**

**ACKNOWLEDGEMENT OF OFFER TO READ AND QUESTION HIPPA NOTICE OF PRIVACY PRACTICES:** This is to certify that I have been provided a copy of **D&H Therapy Associates, LLC's** NOTICE OF PRIVACY PRACTICES as has been mandated by the Health Care Information Privacy and Portability Act (HIPPA). I have been given the opportunity to ask questions which have been answered to my satisfaction.

**ACKNOWLEDGEMENT OF RECEIPT OF D&H's PATIENT GUIDE:** I hereby certify that I have been provided a copy of **D&H Therapy Associates, LLC's** patient guide.

**CONSENT TO TREATMENT AND RECEIPT OF SERVICES:** I voluntarily consent to the provision of services at **D&H Therapy Associates, LLC** for evaluation and treatment or testing relative to my diagnosis/medical condition as directed by my referring physician. I understand that the provider may request other practitioners, to participate in my care. I understand that based upon the findings from my initial assessment, the therapist or their designee will explain to me their recommendations and, as applicable, establish a plan of care in cooperation with myself and my referring physician which may be modified during my treatment sessions as determined by my reports, physical presentation and clinical findings. I understand that, with few exceptions, providers are employees of the center. I understand that specific testing may require separate consent. I further understand that the practice of rehabilitation and medicine is not an exact science and I acknowledge that no guarantees been made to me concerning the results of evaluation, treatment or testing.

**AUTHORIZATION FOR RELEASE OF INFORMATION TO PAYORS:** I authorize **D&H Therapy Associates, LLC** and any provider administering care to me, including, but not limited to physical therapist, occupational therapists and functional capacity assessment specialists to release medical and or other information necessary for the 1) completion of insurance claims or receipt of benefits, 2) review the quality and appropriateness of my care by representatives of external agencies designated by law to conduct such review. I understand that **D&H Therapy Associates, LLC** will forward copies of all or part of my medical record to my Referring Physician and/or any physician or facility participating in my care or continuation of care. If my care is related to an accident at work, I understand that my employer's Workers' Compensation Carrier will also have access to information contained in my record. I specifically authorize release of the following information which may be included in my medical record if it applies to me: AIDS, HIV, presence of a sexually transmitted disease, mental illness and/or drug or alcohol addiction or abuse.

**DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY INSURANCE POLICIES:** I authorize my insurers to pay benefits, which would otherwise be payable to me under my insurance policies, directly to **D&H Therapy Associates, LLC** and/or to the provider administering the professional Services to me..

**MEDICARE AUTHORIZATION:** I certify that I am not currently receiving any services in my home that are being supported by the Medicare program, also referred to as a Home Health Episode of Care. I understand that if I am or do receive any home health services during my care at **D&H Therapy Associates, LLC** that Medicare will not pay for the services I receive at **D&H Therapy Associates, LLC** and I personally will be responsible for payment of these services. I certify that the information given by me in applying for payment of Medicare benefits under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and the Center for Medicare and Medicaid Services (CMS)(formerly known as the Healthcare Financing Administration (HCFA)) or its intermediaries or carriers any information needed for this and/or related Medicare claim. I request the payment of authorized benefits be made on my behalf to **D&H Therapy Associates, LLC**.

**WORKER'S COMPENSATION:** In the event that I have identified that my injury was a result of a work related incident, I hereby authorize **D&H Therapy Associates, LLC** to contact my employer to establish or verify the workers compensation carrier that will process claims relative to my care for this injury and to identify the physical job demands required for my employment and any other information that is relative to my ability to return to work. I understand that not all potential workers compensation claims filed are accepted for liability. As such, I agree, upon registration, to provide to **D&H Therapy Associates, LLC** my personal health insurance that I hereby authorize **D&H Therapy Associates, LLC** to bill should workers compensation deny or not provide acceptance of a valid claim within 60 days of my initial visit.

**MOTOR VEHICLE and PERSONAL INJURY:** In the event that I allege that my injury was sustained as a result of another party's negligence, I will provide **D&H Therapy Associates, LLC** my personal health insurance information which I hereby authorize to be billed as the primary carrier to avoid potential timely filing denials with my carrier should the liability claim be denied. I agree to also provide at registration, the third party insurance carrier information. I authorize **D&H Therapy Associates, LLC** to bill the third party insurance carrier for all services received in the event of a denial from my health insurance carrier or as a secondary carrier for my deductible, co-payment or co-insurance upon payment from my health insurance carrier. I agree to provide the name of the attorney pursuing my claim for damages. I also agree to sign a contractual lien for payment (Lien). If I or my attorney refuse or fail to sign the Lien, I understand that any unpaid balances shall then be due **D&H Therapy Associates, LLC** post insurance submission and response will become immediately due and payable.

**CANCELLATION/NOSHOW:** In the event I need to cancel an appointment, I understand that I must provide a **24 hour notice** during **D&H Therapy Associates, LLC's** normal business hours otherwise I understand that I will be charged a \$25.00 fee which I agree to promptly pay.

**FINANCIAL RESPONSIBILITY:** Most insurances policies provide coverage for the services provided by **D&H Therapy Associates, LLC;** however, this office makes no representation that yours does. Insurance policies differ greatly in terms of provider requirements, deductibles, co-insurance, co-payments and visit allowances. Because of these variations, this consent reminds that the patient or guardian is personally responsible for any deductible, co-payment, co-insurance or any unpaid balances due to non-payment by the insurance carrier. **D&H Therapy Associates, LLC** will make all efforts to obtain and meet the necessary requirements for reimbursement from the third parties provided to **D&H Therapy Associates, LLC** as having responsibility to compensate for services rendered. It is the sole responsibility of the patient or guardian to understand and adhere to all aspects of their third party healthcare insurance contract. It is further understood that patients or guardian not having third party reimbursement contracts (TPRCs) are themselves responsible for compensating **D&H Therapy Associates, LLC** for services rendered. I agree to notify **D&H Therapy Associates, LLC** immediately of any change in information relative to my claim; change in insurance carrier or plan, my billing address, or attorney representing my case. Should bills/invoices be sent to the address on file and returned as undeliverable return to sender as a result of incorrect information, upon receipt of the returned mail, without further notice, the account will be forwarded to the collection attorney and all costs and fees of collection will be applied as identified below for delinquent accounts. I agree that should I make payment on my account with a personal check and that check is returned unpaid by the bank, I will be charged a fee of \$35.00 of which I will promptly pay **D&H Therapy Associates, LLC**. Unpaid patient balances 30 days or older will be billed interest at 1.5% monthly (18%) annually. While we hope that it will never be necessary, accounts delinquent of 60 days or longer or accounts is arrears of an agreed upon payment plan, will be forwarded, without further notice, to our collection attorney. In this event, in addition to your account balance, you will be responsible for the full costs of such collections and the attorneys' fees in the amount of 33.33% of the total account balance.

**MEDICAL RECORDS:** I will notify all parties that require a copy of my medical record that all requests must be submitted to **D&H Therapy Associates, LLC's** main office at 100 Smithfield Avenue, Pawtucket, RI 02860 for processing. A fee for the retrieval and processing of the record may be applicable.

**SIGNATURE:** I have read the information above or have had it read to me. I understand the information and have had my questions answered to my satisfaction. My signature below verifies that I have consented to the above.

**A Photocopy of this Consent Acknowledgement Authorization and Assignment shall be considered effective and valid as the original.**

\_\_\_\_\_  
Signature of Authorized Representative (\*)      Relationship to Patient      (\*)Reason for Representative Giving Consent      Date

\_\_\_\_\_  
Signature of Patient      Date      Signature of Witness      Date



## Medical Questionnaire/History

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

Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Please briefly tell us about the problem that brings you to visit us today: \_\_\_\_\_

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

When did this begin: \_\_\_/\_\_\_/\_\_\_? Are your symptoms:  Improving  Getting worse  About the same  Intermittent

What aggravates your condition:  Standing  Walking  Sitting  Lying down  Bending  Lifting  Twisting  
 Coughing  Other explain: \_\_\_\_\_

Have you had these symptoms before?  No  Yes If yes, when: \_\_\_/\_\_\_/\_\_\_ Explain: \_\_\_\_\_

Have you ever received therapy before for this problem:  No  Yes, Where? \_\_\_\_\_ When? \_\_\_/\_\_\_/\_\_\_

Are you or have you recently received services from a homecare agency?  No  Yes, Who \_\_\_\_\_

Please check off any of the following conditions you have or had in the past:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Heart attack             | <input type="checkbox"/> Shortness of breath                    | <input type="checkbox"/> Bowel or bladder problems    |
| <input type="checkbox"/> Heart palpitations       | <input type="checkbox"/> Asthma or allergies                    | <input type="checkbox"/> Thyroid problems             |
| <input type="checkbox"/> Angina                   | <input type="checkbox"/> Other lung problems                    | <input type="checkbox"/> Osteoporosis                 |
| <input type="checkbox"/> Chest pain with exertion | <input type="checkbox"/> Heartburn, stomach or intestinal upset | <input type="checkbox"/> Headaches                    |
| <input type="checkbox"/> Heart murmur             | <input type="checkbox"/> High Cholesterol                       | <input type="checkbox"/> Frequent sprains or strains  |
| <input type="checkbox"/> Abnormal heart rate      | <input type="checkbox"/> History of ulcers                      | <input type="checkbox"/> Joint pain or swelling       |
| <input type="checkbox"/> Pacemaker                | <input type="checkbox"/> Cancer                                 | <input type="checkbox"/> History of fractures         |
| <input type="checkbox"/> Any other heart problems | <input type="checkbox"/> Chance of pregnancy                    | <input type="checkbox"/> Metal implants/plates/screws |
| <input type="checkbox"/> High blood pressure      | <input type="checkbox"/> Loss of appetite                       | <input type="checkbox"/> History of trauma            |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Night sweats or fever                  | <input type="checkbox"/> History of seizure/epilepsy  |
| <input type="checkbox"/> Low blood sugar          | <input type="checkbox"/> History of neck or back pain           |   |

Do you have any other current or past medical conditions that we should be aware of? \_\_\_\_\_

On a pain scale of 0 (none)-10 worst, please rate your current pain level: \_\_\_\_\_

Please list all surgeries you have had and their dates:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Therapist: \_\_\_\_\_

Date: \_\_\_\_\_



# D&H THERAPY ASSOCIATES, LLC

## NOTICE OF PRIVACY PRACTICES

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.**

### **Our Pledge regarding Your Protected Health Information**

We understand that health information about you is personal and we are committed to protecting that information. This Privacy notice applies to all of your health information, including 1) records relating to your care at our facilities and/or 2) healthcare records received by our organization from another source.

We are required by law to 1) keep your PHI confidential; 2) give you this notice; and 3) follow the terms of the current Privacy Notice.

### **Our Duty to Safeguard Your Protected Health Information**

We are required by a federal law entitled Health Insurance Portability and Accountability Act (HIPPA) to safeguard your Protected Health Information (PHI) and provide you a notice of our privacy practices with respect to information we collect and keep about you.

We reserve the right to change our privacy practices and this 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 each office and a copy available upon request.

### **For More Information**

Our Privacy Officer, Kim Havunen, can be reached at 401-725-9666 to answer your questions about our privacy practices.

### **How We Use and Disclose Your Protected Health Information**

The following categories describe different way we may use and disclose your PHI.

For **treatment** we may use or disclose your PHI to your referring physician, other providers in our practice assisting involved in your treatment and health care providers outside our practice who may also be involved in your care. For example, a therapist may recommend further testing agreed upon by your referring physician or a specialist consult. The different providers involved in your care may share information about you in order coordinate the best possible care for you.

For **payment** we may use or disclose your PHI to bill and collect **payment** from you, your insurance company or a third party payer for the services you receive. For example, we may need to tell your health insurance carrier about your planned treatment to attain authorization for services or your diagnosis to support that the service should be covered.

For **Health Care Operations** we may use or disclose your PHI for practices operations. For example, reviewing records to see how care can be improved, contacting you with information about treatment alternatives, training our staff on your diagnosis and treatment, or review competence of health care providers.

For **notices and appointments**, we may use your PHI to provide notice to you. For example, we may leave a message at your home, on an answering machine or voicemail regarding a receipt of your referral, authorization received for service, satisfaction surveys, insurance benefits/limitations, to schedule your appointment or provide a reminder or confirmation of a scheduled appointment.

At times our organization contracts services with **business associates** where disclosure to your PHI may be necessary for them to perform their job. To protect your PHI we require the associate to appropriately safeguard your PHI. For example, computer hardware and/or software consultants.

## **PHI We May Disclose Without Your Permission**

The law provides that we may use or disclose your PHI from our records (even after your death) without your permission in the following circumstances. As required by law, we will disclose your PHI when required to do so by law, to investigate reports of abuse or neglect and to report an incident to the appropriate law enforcement agency.

**Research:** In certain circumstances and under supervision, we may disclose information for medical research to researchers when the proposal has been reviewed and approved by the organizations partners and provides protocols to ensure the privacy of your PHI.

**Workers Compensation:** We may disclose PHI to the extent authorized by and to the extent necessary to comply with laws relating to employment related injuries.

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

In certain circumstances, we are **required by law** to use and disclose PHI 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.

## **Your Rights**

You have the right to ask us to **restrict** how your PHI is used or disclosed. You must make your request in writing and tell us what information you want to limit and to whom the limits apply. For example, you could ask that we not disclose to your insurance carrier information about your treatment. We are not required to agree with your request.

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 at an alternative address. You must make your request in writing. You do not need to provide a reason for your request. We will honor all reasonable requests.

In most cases, you have a right to **inspect and obtain a copy** of your record. You must make the request in writing. This may be subject to certain limitations. You may be charged a fee for the cost of copying your records.

If you believe there is a mistake or missing information in our record of your PHI, you may ask us to **amend** the information. Your request must be made in writing and you must provide sufficient support of your request. 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 on or after April 14, 2003 of your PHI for purposes other than those listed in the Privacy Notice. Your request must be in writing and state the period of time, not longer than seven years. The first request made within a twelve month period will be free.

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.

You also have the right to **authorize release of your** PHI to others. Your request must be submitted in writing. You may revoke an authorization at any time by submitting that request in writing. This will not affect any use or disclosure made by us before the revocation.



## PATIENT GUIDE

This guide provides an outline of our policies to help ensure the smooth operation of each clinic and allow for timely appointment sessions and to help you understand some of your responsibilities. It is very important that you provide the front desk of any change in insurance, phone number, address or change in your health or condition since your last visit.

### **OFFICE HOURS:**

Patients are seen by appointment only in the following locations. The normal hours of operation at each of these facilities are identified below. On occasion a schedule change is necessary to meet the need of a client or accommodate a clinician schedule change.

	Pawtucket Office 100 Smithfield Ave Pawtucket, RI 02860 401-725-9666	Lincoln Office 2 Wake Robin Rd Suite 101 Lincoln, RI 02865 401-333-1747	Greenville Office 466 Putnam Pike Smithfield, RI 02917 401-233-3977	EPOCH - East Side One Butler Ave Providence, RI 02906 401-273-5031	POWR (our affiliate) 650 Ten Rod Rd N. Kingstown, RI 02852 401-667-7997
Monday	8:00 am – 6:30 pm	7:00 am – 4:00 pm	6:00 am – 6:00 pm		7:00 am – 6:00pm
Tuesday	8:00 am – 1:00 pm	9:30 am – 6:30 pm	By appointment	8:00 am – 1:30 pm	7:00 am – 4:00pm
Wednesday	8:00 am – 6:30 pm	7:00 am – 4:00 pm	6:00 am – 6:00 pm		7:00 am – 6:00pm
Thursday	2:00 pm – 6:30 pm	9:30 am – 6:30 pm	By appointment	8:00 am – 1:30 pm	7:00 am – 4:00pm
Friday	8:00 am – 1:00 pm	7:00 am – 1:00 pm	6:00 am – 6:00 pm		By appointment

### **BILLING QUESTIONS:**

Please contact our billing department for any question you may have on a statement you receive, to schedule payments on your account or for any other questions you may have on your account. The central billing office can be reached at 401-725-9666 ext 202, Monday thru Friday, 8:00 am to 3:30 pm.

### **URGENCIES:**

Please feel free to call any time if you feel that you need to speak with the therapist. Calls made after normal hours will be forwarded to an voice mail for you to leave a message. Calls will be returned at the start of the next business day.

If you feel that the problem requires an immediate response and the therapist is not available or it is after hours please contact your referring physician for appropriate advice.

### **TIMELINESS:**

We make a sincere attempt to adhere to the schedule as much as possible. Occasionally, there are situations that arise that detain the therapist. It is important for you to be on time for your scheduled appointments. If you are late, we will try our best to provide your full treatment but at times that may not be possible. If you know you are running late, please call and notify the office. They will advise if an accommodation is possible.

### **CANCELLATIONS/NO SHOWS:**

If you are unable to keep your appointment please contact us to reschedule your appointment. We make every attempt to reschedule your appointment so as not to interrupt your treatment plan. There is a \$25.00 cancellation fee for failing to provide proper notice or for not showing for your scheduled appointment. This fee is not covered by your insurance; it is your responsibility to pay. Failure to keep two appointments without notice or three cancellations may result in you being referred back to your physician for reassessment ahead of schedule.

Please understand that your pain will probably increase and decrease as your course of treatment progresses before you reach maximum improvement. If you're in pain, come in so it can be assessed. If you're pain free, it's time to begin a progressive correction of the underlying cause of your problem. Neither of these situations is a legitimate reason to cancel or not keep your appointment.

When you don't show as scheduled, three people are hurt: you because you don't get the treatment recommended by your doctor and therapist; the therapist who now had reserved that time for you; and another patient who could have been scheduled for treatment if you had given proper notice.

Tardiness, cancellations and no shows are documented in the medical record and reported to case manager and adjusters which can affect benefits.

If there are extenuating circumstances, please advise the receptionist at the time of cancellation or reschedule of your appointment.

### **WHAT TO BRING:**

- If you are to be seen for a hip, knee or ankle injury, please bring a pair of shorts to wear during your therapy session.
- If you have been seen by a specialist or have undergone diagnostic testing, please bring any available test results. Ex, MRI and X-rays.
- If you are unable to speak English, please bring an interpreter with you as good communication is essential for proper treatment.

### **SMOKING:**

Smoking is prohibited in all areas of our building.