Patient Data Sheet

CREST PHYSICAL THERAPY

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____
Last First MI

Social Security No.:_____ Sex: ❑ M ❑ F Marital Status: ❑ M ❑ S ❑ D ❑ W

Address: _____ City:_____ State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____
OK to leave detailed message? ❑ Yes ❑ No OK to leave detailed message? ❑ Yes ❑ No OK to leave detailed message? ❑ Yes ❑ No

Email Address: _____ Preferred method of contact: _____

Notify in case of Emergency: _____ Phone number: _____

Race: ❑Am Indian ❑ Asian ❑Native Hawaiian or Pac Islands ❑White ❑Other Ethnic Background: ❑ Hispanic/Latino ❑ Non-Hispanic/Latino
Smoking Status: ❑ Every Day Smoker ❑ Some Day Smoker ❑ Former Smoker ❑ Never Smoker ❑ Unknown

INSURANCE SUBSCRIBER INFORMATION

Relationship to patient: ❑ Self ❑ Spouse ❑ Parent ❑ Other

Name: _____ Birthdate: _____

Address: _____

Home Phone: _____ Work Phone: _____ Social Security No. _____

Employer: _____ Employer address: _____

Sex: ❑ M ❑ F Occupation: _____

ACCIDENT INFORMATION

Did you have Surgery: ❑ Yes ❑ No Surgery Date: _____ Accident/Injury type: ❑ Workers Comp* ❑ Auto ❑ Other:

Accident / Injury Date / Date Doctor was seen for this problem: ____/____/____ Briefly describe accident: _____

*If Worker's Comp - Employer: _____ State: _____

INSURANCE POLICY INFORMATION

This information will be used for billing purposes; please present your insurance card and a photo ID to the front desk receptionist.

Primary Insurance Name: _____ Phone: _____

Policy / Claim #: _____ Group # : _____

Insured Name: _____ Authorization / Pre-Certification: _____

Secondary Insurance Name: _____ Phone: _____

Policy / Claim #: _____ Group # : _____

Insured Name: _____ Authorization / Pre-Certification: _____

Have you received physical therapy, occupational therapy, or chiropractic services this year? ❑ Yes ❑ No

I have reviewed the above information and verify that it is correct.

Patient / Guardian signature: _____ **Date:** _____

********** OFFICE USE ONLY **********

Referring Physician:_____ Phone #:_____ UPIN #:_____

Admit Date: ____/____/____ RX Date: ____/____/____ Therapist Name: _____

Body Part / PT / OT / DURATION: _____

Service Class: _____ FSC Code: _____ Intake Completed By: _____

How Did You Hear About Crest?

CREST PHYSICAL THERAPY

Please check all that apply:

☐ Returning Patient
If you are a returning patient, are you returning due to an EMAIL sent to you? ☐ Yes ☐ No

☐ Doctor Referral: _____
Referring Doctor's Name

☐ Insurance Company Referral

☐ Family Member or Friend

☐ Atlantic Club Gym Member

☐ Social Media: ☐ Facebook ☐ Instagram ☐ Other: _____

☐ Internet Search: ☐ Google ☐ Yelp ☐ Other: _____
What key word(s) did you search? _____

☐ Advertisement: ☐ Newspaper/Magazine Ad ☐ Digital Internet Ad
Where did you see the ad? _____

☐ Newsletter ☐ Flyer ☐ Billboard ☐ Radio ☐ Other: _____

☐ Hospital Program Referral: ☐ Bariatric Program ☐ Cancer Rehab Program ☐ Other: _____

☐ Crest Employee: Name of Crest Employee _____

☐ Other: _____
Please Tell Us How You Heard of Us

_____ _____
Patient Name Printed Referring Doctor's Name

_____ _____
Patient Email Date

OFFICE USE ONLY

Intake Reviewed by: _____ Date: _____

Financial Policy Statement

CREST PHYSICAL THERAPY

CREST PHYSICAL THERAPY calls your insurance company in advance of your treatment to verify what they will and/or will not cover, and what your responsibility may be. This is an "estimation" of your benefits and not a guarantee they will pay that way. Your total share may be more than the payments (i.e., co-pays) you have been making to the facility (*CREST*).

Your insurance company may send Payments and Explanations of Benefits directly to you. The explanation of benefits itemizes what was covered/paid to both the patient and to *CREST PHYSICAL THERAPY*. *CREST PHYSICAL THERAPY* will send a letter/bill asking for any further amounts due for that billing period, if any. You may also receive an automated reminder call for any balance due at the end of your treatment. If at any time you feel your insurance company processed your claim incorrectly, please contact them directly.

If at any time during your therapy, your insurance changes, please inform facility front desk as soon as possible.

Benefit Assignment/Release of Information

I request that payment of authorized benefits be made either to me or on my behalf to Crest Physical Therapy for services furnished by Crest Physical Therapy. If these benefits are not assigned to Crest Physical Therapy, I agree to forward the practice all health insurance and/or third-party payments I receive for services immediately upon receipt. I will promptly pay Crest Physical Therapy for all amounts not paid by my insurer(s) and for which I am responsible according to my insurance plan's participation criteria. This includes but is not limited to co-insurance, deductibles, and non-covered items. I authorize release to the indicated insurance carrier any medical information about me needed to determine these payments for related services.

By signing below, you agree to forward the payment and Explanation of Benefits to *CREST PHYSICAL THERAPY*. Without the Explanation of Benefits, the payments may not be applied correctly, which could result in you being sent a bill for your visits.

Please be advised that you must make a co-insurance/copay/deductible payment for each visit with Crest Physical Therapy. Your co-insurance/copay/deductible is $_____, as per your insurance company. By signing below, you agree to make your co-insurance/copay/deductible payment on each visit. We accept Visa, MasterCard, American Express, checks, money orders, and cash.

No Show Policy and Fee

It is the policy of this facility to charge a **"no show" fee** of $25.00 to patients who miss or cancel an appointment with less than 24 hours' notice. This fee may be waived at the discretion of the CREST Administrative Director based on individual circumstances of the patient (e.g., family illness or accident). Should you cancel or no show three times over the course of one month with less than 24 hours' notice we will no longer be able to schedule appointments in advance for you, however, you will be able to call on the day you would like to come in to schedule during an open time.

Thank you for choosing *CREST PHYSICAL THERAPY*.

By signing below you are stating that you have read and understand this form:

_____ _____

SIGNATURE DATE

_____

PRINT NAME

OFFICE USE ONLY

Intake Reviewed by: _____ Date: _____

Notice of Privacy Practices

CREST
PHYSICAL THERAPY

I. 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.

II. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

We are legally required to protect the privacy of your health information. We call this information "protected health information", or "PHI" for short and it includes information that can be used to identify you that we've created or received about your past, present, or future health condition, the provision of health care to you, or the payment for this health care. We must provide you with this notice about our privacy practices that explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice.

However, we reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Before we make an important change to our policies, we will promptly change this notice and post a new notice in [insert location where notice will be posted, e.g., main reception area]. You can also request a copy of this notice from the contact person listed in Section IV below at any time.

III. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your specific authorization. Below, we describe the different categories of uses and disclosures.

A. Uses and Disclosures Which Do Not Require Your Authorization.

We may use and disclosure your PHI without your authorization for the following reasons:

1. For treatment. We may disclose your PHI to hospitals, physicians, nurses, and other health care personnel who provide you with health care services or are involved in your care. For example, if you're being treated for a knee injury, we may disclose your PHI to an x-ray technician in order to coordinate your 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. For example, we may provide portions of your PHI to our billing department and your health plan to get paid for the health care services we provided to you.

3. For health care operations. We may disclose your PHI in order to operate this practice. For example, we may use your PHI in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make sure we're complying with the laws that affect us.

4. When a disclosure is required by federal, state or local law, judicial or administrative proceedings, or law enforcement. For example, we make disclosures when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with gunshot or other wounds: or when ordered in a judicial or administrative proceeding.

5. For public health activities. For example, we report information about births, deaths, and various diseases, to government officials in charge of collecting that information, and we provide coroners, medical examiners, and funeral directors necessary information relating to an individual's death.

6. For health oversight activities. For example, we will provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.

7. For purposes of organ donation. We may notify organ procurement organizations to assist them in organ, eye, or tissue donation and transplants.

8. For research purposes. In certain circumstances, we may provide PHI in order to conduct medical research.

9. To avoid harm. In order to avoid a serious threat to the health or safety of a person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.

10. For specific government functions. We may disclose PHI of military personnel and veterans in certain situations. And we may disclose PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations.

11. **For workers' compensation purposes.** We may provide PHI in order to comply with workers' compensation laws.

12. Appointment reminders and health-related benefits or services. We may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits we offer.

B. Use and Disclosure Where You Have the Opportunity to Object:

1. Disclosures to family, friends, or others. We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part.

2. All Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described above, we will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing to stop any future uses and disclosures (to the extent that we haven't taken any action relying on the authorization).

3. Incidental Uses and Disclosures. Incidental uses and disclosures of information may occur. An incidental use or disclosure is a secondary use or disclosure that cannot reasonably be prevented, is limited in nature, and that occurs as a by-product of an otherwise permitted use or disclosure.

However, such incidental uses or disclosure are permitted only to the extent that we have applied reasonable safeguards and do not disclose any more of your PHI than is necessary to accomplish the permitted use or disclosure. For example, disclosures about a patient at a nursing station that might be overheard by personnel not involved in the patient's care would be permitted.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI.

You have the following rights with respect to your PHI:

A. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your requires, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

B. The Right to Choose How We Send PHI to You. You have the right to ask that we send information to you to an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the format you requested.

C. The Right to See and Get Copies of Your PHI. In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we don't have your PHI but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed.

If you request copies of your PHI, we will charge you $1 for each page. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. The Right to Get a List of the Disclosures We Have Made. You have the right to get a list of instances in which we have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care operations, directly to you, to your family, or in our facility directory. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or in compliance with National Instant Criminal Background Check System as of 1/7/14.

We will respond within 60 days of receiving your request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you $10 for each additional request.

E. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. We will respond within 30 days of receiving your request in writing. You must provide the request and your reason for the request in writing. We may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.

F. The Right to Get This Notice by E-Mail. You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Ave., S.W.; Room 615F; Washington, DC 20201. We will take no retaliatory action against you if you file a complaint about our privacy practices.

VI. PERSON TO CONTACT FOR INFORMATIN ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact: Physicians' Practice Enhancement, LLC, Attn: Human Resources; 66 West Gilbert Street, Suite 100; Red Bank, New Jersey 07701-4918; (732) 212-0060; e-mail: info@ppenet.com.

VII. EFFECTIVE DATE OF THIS NOTICE.

This notice went into effect on January 1, 2015.

Patient Agreements

CREST PHYSICAL THERAPY

Please read the following statements and indicate your acknowledgement and/or authorization for each below with your initials:

_____ I hereby authorize the staff of *CREST PHYSICAL THERAPY* to provide and perform any medical care and treatment deemed necessary or beneficial for my health and wellbeing and appropriate in diagnosing or treating my physical and/or mental condition.

_____ *CREST PHYSICAL THERAPY* calls your insurance company in advance of your treatment to verify what they will and/or will not cover, and what your responsibility may be. Please realize that the information they give us is just an "estimation" of your benefits and not a guarantee they will pay that way. All payments you make at the facility are only intended to go towards your total patient share and may not be your final responsibility. If at any time during your therapy, your insurance changes, please inform facility front desk as soon as possible.

_____ Your insurance company may send Payments and Explanations of Benefits directly to you. The explanation of benefits itemizes what was covered/paid to both the patient and to *CREST PHYSICAL THERAPY*. *CREST PHYSICAL THERAPY* will send a letter/bill asking for any further amounts due for that billing period, if any. You may also receive an automated reminder call for any balance due at the end of your treatment. If at any time you feel your insurance company processed your claim incorrectly, please contact them directly. Bills unpaid for more than 90 days may be turned over to a collection agency, Wakefield & Associates.

_____ *CREST PHYSICAL THERAPY* collects information including your home address, home and mobile phone number, and email to deliver patient statements, alerts, newsletters, surveys, and other communications. You can opt out of marketing communications at any time. We will never sell, rent, or give away our patient information list for 3rd party marketing.

PATIENT PERMISSION TO SHARE PROTECTED HEALTH INFORMATION

_____ I hereby authorize the staff of *CREST PHYSICAL THERAPY* to use or disclose my health information (referred to as "Protected Health Information") to any healthcare provider and/or employee of Crest Physical Therapy. The Protected Health Information (PHI) I am authorizing for use of disclosure is the standard release of information (includes typed diction and therapy notes) and specific information from my chart which includes: _____.

_____ I hereby authorize and request *CREST PHYSICAL THERAPY* to disclose my PHI to the person(s) or institution(s) listed below. I understand that this authorization will expire 180 days from signing, unless an earlier date is indicated: _____.

Authorized Name(s)	Relationship to patient	Authorized Mailing Address

_____ I understand that *CREST PHYSICAL THERAPY* has the right to bill me $1.00 per page for each copy of my PHI.

CREST PHYSICAL THERAPY

FINANCIAL POLICY STATEMENT

_____ I understand my responsibility for the payment of my account.

_____ 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.

RECIEPT OF NOTICE OF PRIVACY PRACTICES

_____ I have received and reviewed the Notice of Privacy Practices.

REVOKING RIGHTS FOR PATIENT AGREEMENT

_____ I understand that I have the right to revoke this Authorization, if the revocation is in writing, except if *CREST PHYSICAL THERAPY* has taken action in reliance upon this Authorization or, if this Authorization was given as a condition of obtaining insurance coverage, other law provides that the insurance company has the right to contest a claim under the insurance policy. I understand that I may revoke this Authorization by sending a written request to:
Crest Physical Therapy
66 West Gilbert Street
Red Bank, NJ 07701

This consent shall remain in effect until revoked in writing.

By signing this Authorization, I acknowledge that I have read and understand this Authorization.

_____	_____	_____	_____
Signature (Patient)	Date	Signature (Authorized Representative)	Date

_____	_____
Name Printed	Relationship of Authorized Representative to Patient

_____	_____
Patient's Telephone #	Patient's Date of Birth

OFFICE USE ONLY

Intake Reviewed by: _____ Date: _____

Patient Medical History

CREST PHYSICAL THERAPY

Patient Name _____ ID #: _____ Date:_____

Referring Physician: _____ Family Physician: _____

Regarding this injury: First Doctor Visit: ____ / ____ / ____ Last day Worked: ____ / ____ / ____ Date Returned to Work: ____ / ____ / ____

Have you had surgery for this injury? ❒YES ❒NO Took place in: ❒ Hospital ❒ Surgery Center Is an attorney involved in this case? ❒YES ❒NO

Number of surgeries: _____ Type of Surgery: _____

Have you had any of the following medical or rehabilitative services for this injury/episode?

	YES	NO		YES	NO		YES	NO
Massage Therapy			CT Scan			Neurologist		
General Practitioner			EMG/NCV			Myelogram		
Occupational Therapy			MRI			Chiropractor		
Emergency Room Care			Podiatrist			Orthopedist		
Physical Therapy			X-Rays			Other: _____		

Have you had two (2) or more falls, or any fall resulting in injury, in the past year? ❒YES ❒NO

If yes, please explain: _____

Do you now have or have you ever had ANY of the following?

	YES	NO		YES	NO
Allergies			Heart Attack or Surgery		
Vision or Hearing Difficulties			Do you have a Pacemaker?		
Weight Loss/Energy Loss			Shortness of Breath/Chest Pain		
Numbness or Tingling			Coronary Heart Disease or Angina		
Weakness			Congestive Heart Disease		
Dizziness or Fainting			Stroke/TIA		
High Blood Pressure			Blood Clot/Emboli		
Bowel or Bladder Problems			Varicose Veins		
Emotional/Psychological Problems			Anemia		
Thyroid Disease or Goiter			Joint Replacement Surgery		
Epilepsy/Seizures			Any Pins or Metal Implants?		
Cancer or Chemotherapy/Radiation			Do you use tobacco?		
Sleeping Problems/Difficulties			Are you pregnant?		
Diabetes			Leg/Ankle/Foot:: ❒ Injury ❒ Surgery		
Infectious Diseases			Shoulder: ❒ Injury ❒ Surgery		
Arthritis			Elbow/Hand: ❒ Injury ❒ Surgery		
Osteoporosis			Neck: ❒ Injury ❒ Surgery		
Gout			Back: ❒ Injury ❒ Surgery		
Hernia			Knee: ❒ Injury ❒ Surgery		

Smoking Status: ❑Every Day Smoker ❑Some Days Smoker ❑Former Smoker ❑Never Smoker ❑Unknown

List any other information that would assist us in your care, i.e. recent surgeries, etc.:

_____

_____

_____

 Rev. 02/2021

Patient Medical History

CREST PHYSICAL THERAPY

Are you aware of your diagnosis and prognosis as explained by your doctor? ❒YES ❒NO

Based on your awareness, what are your rehabilitation expectations/goals while in this program?

_____

_____

Would you like to speak to a social worker about any aspects of your rehabilitation program? ❒YES ❒NO

Please list the following Medications you are taking below:

Drug Name *(including OTC, herbals, vitamins)*	Dosage *(mg, units, etc.)*	Frequency *(once a day, etc.)*	Route *(oral, topical, etc.)*

Are you allergic to any medications? ❒YES ❒NO

If yes, list Medications: _____

Patient/Guardian Signature: _____ Date: _____

OFFICE USE ONLY

Intake Reviewed by: _____ Date: _____

