

**Great Neck:**  
475 Northern Boulevard, Suite 11, Great Neck, NY 11021  
Phone: 516-829-0030 Fax: 516-466-7723

**Farmingdale:**  
309 North West Drive, Farmingdale, NY 11735  
Phone: 516-420-2900 Fax: 516-420-2908

**In-Home Therapy: 516-829-0030**

**Patient Insurance Notice**

I hereby certify that the insurance information that I have provided to Reddy Care is true and accurate as of the date of service and that I am responsible for keeping it updated. I agree to authorize benefits to be assigned to Reddy Care as requested for services provided by Reddy Care.

I understand Reddy Care will submit a claim to my insurance carrier for the services rendered, but I may receive payment directly for such claim. In the event I receive an Explanation of Benefits (EOB) and a check for the claim from the insurance company, I agree to remit payment to Reddy Care immediately for the full amount received and include a copy of the EOB. I understand that I will be held accountable for any insurance payments sent to my attention and not paid directly to Reddy Care for services rendered.

I understand that, depending on the terms of my insurance coverage, I may have a financial responsibility for services provided by health care professionals at Reddy Care who may not be participating providers in the same plan or network. I understand Reddy Care may collect an advanced payment and/or provide a prompt pay discount for services rendered under a payment arrangement. I understand that any questions about coverage or benefit levels should be directed to my insurance carrier.

I give Reddy Care permission to appeal any services not covered by my insurance carrier on my behalf. If my insurance denies coverage for my treatment, I understand that I will be held financially responsible. I understand and agree that if it becomes necessary to commence legal action for the collection of any outstanding charges on my account, I will be responsible for any costs and or court fees, in addition to the outstanding balance.

By initialing this document, I acknowledge and accept the conditions as explained above for all services received.

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



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### **Home Health Notice for Medicare Beneficiaries**

Reddy-Care wants your insurance to cover your physical therapy treatment.

Please be advised that Medicare **may not** cover out-patient physical therapy (Reddy-Care Physical Therapy services) if they are paying for home health services at the same time.

Home healthcare services include, but are not limited to:

- An aide that comes to your home
- A nurse that comes to your home
- A nurse that comes to your home to draw blood
- A rehabilitation therapist that comes to your home

As a Medicare Beneficiary, I understand that Medicare **may not** cover my out-patient physical therapy during the same time period I am receiving home healthcare services paid for by Medicare.

I understand that if I do receive home healthcare services through Medicare at the same time I receive physical therapy from Reddy-Care, **my physical therapy visits may not be covered.**

I attest that **if at anytime during my treatment at Reddy-Care Physical Therapy I am going to start receiving home health services,** I will inform Reddy-Care Physical Therapy immediately.

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

## MEDICAL HISTORY

Have you ever suffered from any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Conditions	<input type="checkbox"/>	<input type="checkbox"/>	Liver Problems	<input type="checkbox"/>	<input type="checkbox"/>	Dizzy Spells	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Claustrophobia	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Circulation Problems	<input type="checkbox"/>	<input type="checkbox"/>	Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>	Fractures	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Speech Problems	<input type="checkbox"/>	<input type="checkbox"/>	Strokes	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to Cold	<input type="checkbox"/>	<input type="checkbox"/>	Metal Implants	<input type="checkbox"/>	<input type="checkbox"/>
Nervous Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to Heat	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>

Have you suffered from any illnesses not listed above? Yes ☐ No ☐ If yes, please explain:

Have you ever had surgery including this current condition? Yes ☐ No ☐

If yes, please list the type of surgery and the year it was done:

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

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

Have you had therapy for your current condition? Yes ☐ No ☐ If yes, please list:

Location: \_\_\_\_\_ Dates: \_\_\_\_\_ # of Visits: \_\_\_\_\_

Are you currently taking any medications or herbal supplements? Yes ☐ No ☐ If Yes, please list:

Type: \_\_\_\_\_ Dosage: \_\_\_\_\_ Type: \_\_\_\_\_ Dosage: \_\_\_\_\_

Type: \_\_\_\_\_ Dosage: \_\_\_\_\_ Type: \_\_\_\_\_ Dosage: \_\_\_\_\_

Type: \_\_\_\_\_ Dosage: \_\_\_\_\_ Type: \_\_\_\_\_ Dosage: \_\_\_\_\_

What Body Part are we treating? \_\_\_\_\_

Are we treating you as a result of a fall? Yes ☐ No ☐

Have you fallen twice or more in the last year? Yes ☐ No ☐

Describe the history of your present condition. Please provide all important details.

What are your goals or expectations of therapy

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

Physical Therapist Signature: \_\_\_\_\_ Date: \_\_\_\_\_





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### ACKNOWLEDGEMENT FORM - NOTICE OF PRIVACY PRACTICES

This Acknowledgement Form is provided to you as required by the Privacy Rule and related Regulations under the *Health Insurance Portability and Accountability Act of 1996 ("HIPAA")*.

You are asked to initial this form so that we can confirm that you have received it. Your initials only confirm that you have received this Form. Your initials do not mean that you agree with any of the policies and procedures outlined herein.

You may refuse to initial this Acknowledgement Form, at which time our staff is required to document the date and time of your refusal, as well as your reason for not initialing.

I acknowledge that I have received a copy of Reddy Care Physical Therapy's Notice of Privacy Practices, as of the date indicated below.

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

### BUSINESS ASSOCIATES ACKNOWLEDGEMENT

Reddy Care works with the following Business Associates listed below in order to perform the daily functions of the practice.

I understand that as a patient of Reddy Care PT, the following information may be disclosed to these entities:

*Belly Card* (if I sign up) – email address, dates I check-in at Reddy Care  
*Postcard Mania* – demographic information  
*MailChimp* - email address  
*Campaign Manager* - email address  
*Practice Promotions* - demographic information

By initialing below, I attest that I am aware and approve of Reddy Care's Privacy Practices and release of my information to the above entities in the above manner.

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

### HEALTH INFORMATION RELEASE

I authorize Reddy Care Physical Therapy to use and/or disclose Personal Health Information (PHI) about me to the follow person(s) and/or entity (ies):

\*Please list the NAME and RELATIONSHIP to person(s) and entity(ies) below:

Family Member: \_\_\_\_\_

Health Aide: \_\_\_\_\_

Attorney: \_\_\_\_\_

Other: \_\_\_\_\_

### FOR OFFICE USE ONLY:

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.  
☐ Due to an emergency situation, it was not possible to obtain an acknowledgment.  
☐ We were unable to communicate with the patient.  
☐ Other: \_\_\_\_\_

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date



## APPOINTMENT REMINDER CONSENT

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

Complete this form and sign below to give your permission for Reddy-Care Physical Therapy to provide automatic appointment reminder service by email or by cell phone text message.

**Step One: Select One Option Below**

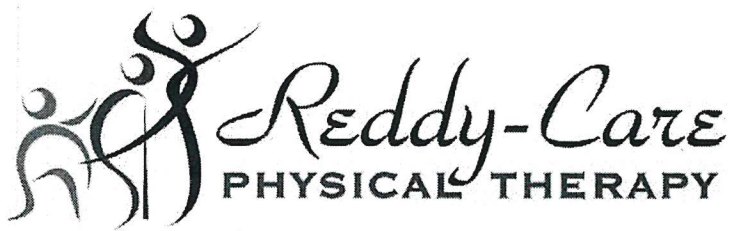
- ☐ Reddy-Care Physical Therapy may send email messages to confirm my upcoming appointments to .  
\_\_\_\_\_ (Enter Email Address)
- ☐ Reddy-Care Physical Therapy may send cell phone text messages to confirm my upcoming appointments  
\_\_\_\_\_ (Enter Cell Phone #)  
*I recognize that normal text messaging rates may apply.*

**Step Two: If you would like text messages instead of email reminders, please indicate your Cell Phone Carrier.**

We cannot set your account up to send email text message reminders without knowing your cell phone carrier. Please indicate your carrier below, if you would like text message reminders:

- ☐ ALLTel
- ☐ AT&T
- ☐ Boost Mobile
- ☐ Cingular
- ☐ Cricket Wireless
- ☐ Metrocall
- ☐ MetroPCS
- ☐ Nextel
- ☐ Qwest
- ☐ Sprint PCS
- ☐ T Mobile
- ☐ US Cellular
- ☐ Verizon
- ☐ Virgin Mobile

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### **Cancellation Policy**

When you are scheduled for a treatment session at Reddy Care Physical Therapy, the time is reserved especially for you. We ask that a 24 hour notice is given if you are unable to make your appointment. If you cancel the same day or do not show up for your appointment, you will be charged a fee of \$25. We care about your health and wellness and need you to be here consistently to receive the care required. Extreme circumstances will be taken into consideration. We are in the business of helping patients get better; help us help you and every one of our patients by not cancelling your appointment.

I understand this policy.

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

**I certify that I have read the foregoing documents and agree to the Terms and Conditions.**

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date





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### **IMPORTANT INFORMATION REGARDING YOUR TREATMENT**

1. Research shows that when a patient arrives 3 times a week for the 5-6 weeks their percentage of improvement is 90% to 95%. When 1-2 times a week it goes down to 68%. In over the 10 years of our practice, we find that when patients are not persistent on getting better and don't show up, they are very likely to come back at a later date with another problem.
2. Insurance companies may not pay for therapy when you come in 1 time a week. This is a new rule passed by Medicare and other insurances tend to follow.
3. Physical therapy is progressive. Don't expect to feel 80-100% better in the first 10 sessions. Generally, if you have had a condition for more than 2 months it may take more time.
4. Scheduling your appointments ahead of time is vital. Many of our patients want specific times and we cannot give preference to one patient over another.
5. Arrive to your therapy on time and ready to go. Without movement the body gradually loses its ability to move, surgery, increased medicine dosages and other medical conditions arise. Your body is your first and primary investment☺ \* DO your home exercise program!
6. My doctor wants me to come in 2 times? We can call the doctor have him concur (which is generally successful) or if there is a condition that merits this, then 2 times a week may be required.
7. I don't want to see a different therapist? Our therapists are exceptionally trained and you may be surprised by a new set of hands/eyes.

### **I'M NOT GETTING BETTER AND IT HAS BEEN 6 WEEKS**

Our concern is your health. Unfortunately, due to prior medical conditions, surgery, environmental factors, chronic pain/dysfunction—over 2 months, multiple areas of dysfunction etc., there are times where patients don't progress as expected. Please bring this issue to your therapist. Our Vice President of Operations (516-829-0030) can assist you managing your issue or concern. Furthermore, the owner Dr. Vinod Somareddy, PT can be called on his cellular phone (516-351-6848) if there is a matter that isn't resolved. We are very concerned about making sure that your progress is sustained and progressed, as we can't guarantee outcomes. Muscles strength and management takes 2-3 weeks to change permanently (similar to weight loss) and requires persistence and dedication on both the therapist and patient. Quitting without saying anything and without asking for further assistance isn't acceptable. We want to help, please let us know.







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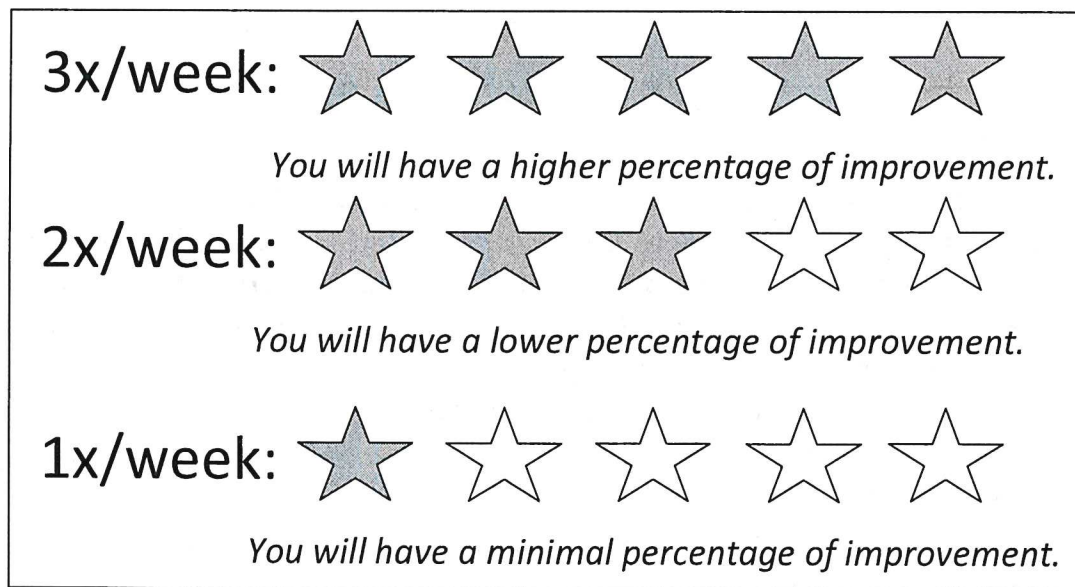
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#### IMPORTANT INFORMATION REGARDING YOUR TREATMENT

Here at Reddy-Care Physical Therapy we pride ourselves on the quality of care that we administer to our patients as well as our therapists ability to diagnose and treat patients in a timely manner. Our therapists diligently decide the course of treatment for each patient because they know that no two patients are alike. With this they are able to determine what will help you get better in the fastest amount of time.

Research shows that when a patient arrives 3 times a week during the course of treatment their percentage of improvement is 90%-95%. When the patient comes 1-2 times per week that percentage goes down to 68%.



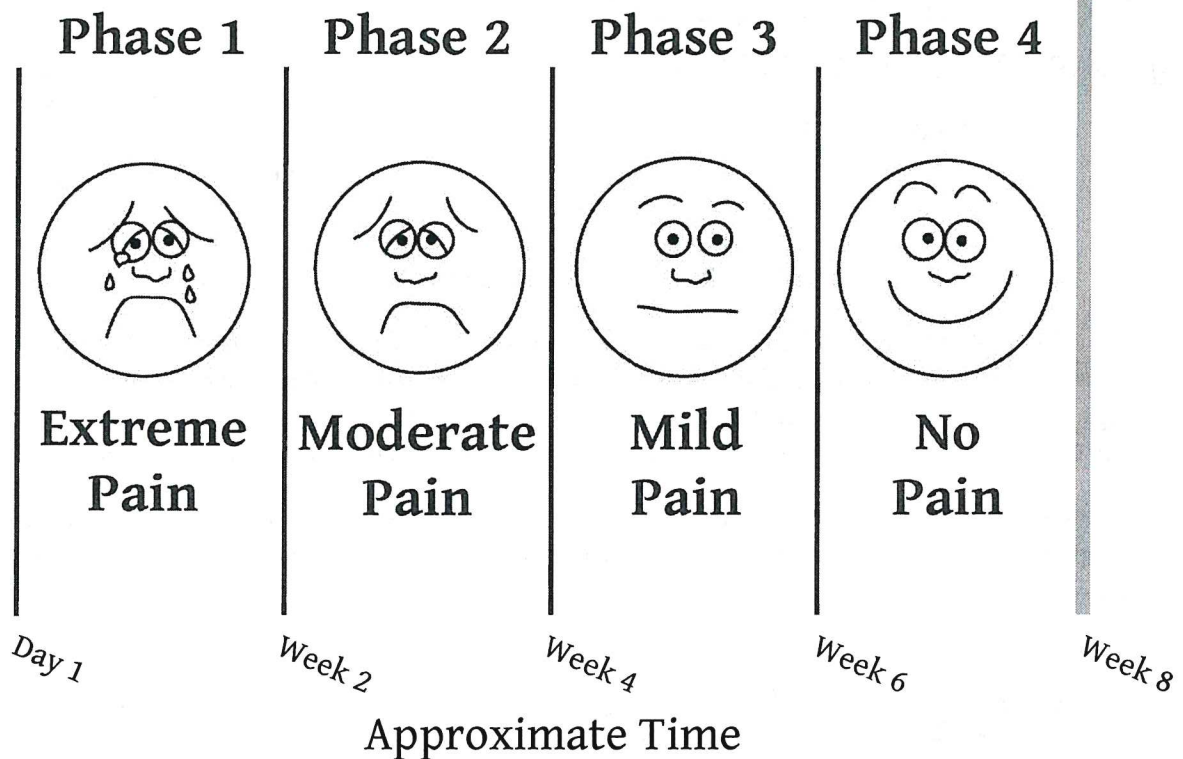
The more committed you are to your therapy, at home and in the clinic, the better the results. Remember, physical therapy is progressive. Do not expect to feel 80-100% better in the first 10 sessions. Generally, if you have had a condition for more than 2 months it will take more time to begin feeling relief. These statistics will vary based on the condition itself, how chronic and long the condition has persisted, and the ability of each individual body to respond to treatment.

Sincerely,



Vinod Somareddy. PT, DPT

# Progression of Your Care



## Reddy Recovery

Our program is designed for you, its important for you to fully complete the program in order for your recovery to be successful and timely. Additional exercises that the therapist assigns should be maintained and completed at home. Some of the prescribed exercises that are done at the clinic are completed with the assistance of auxiliary staff. Throughout your therapy program there are several phases to look forward to during your road to a successful recovery.

- Phase 1: Pain Management — Initially, our program aims to decrease your pain so that furthering yourself in the program is easier and less stressful.
- Phase 2: Range of Motion & Flexibility — After managing your pain, the next step is to increase your flexibility so that you are capable of completing future exercises to improve endurance. Patients completing this phase have a 50% recovery rate.
- Phase 3: Specific Exercise Prescription — Don't expect to progress on your own. Our program eases you into a routine to strengthen your problem area. Patients completing this phase have an 80% recovery rate. Without strength in the problem area there is no permanent gain.
- Phase 4: Functional Endurance Management — This phase is where our program comes to a complete circle, You are capable of performing close to or even better than you have in the past. Patients completing this phase have a 90-100% recovery rate. Completing phase 4 is extremely important. Since this is close to the end of your treatment, you most likely won't be feeling much pain and feeling pretty good. It is not a good idea to just stop coming in because you feel that you've had enough therapy. Both you and the therapist have worked hard to get to this point, therefore deciding not to finish the complete treatment cycle can lead to regression of your results. On your last visit , the therapist will assess your final results which will be sent to your doctor for review. The therapist will also come up with a personalized home maintenance program for you so that you can maintain those results you have achieved in therapy.





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## 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.

**Uses and Disclosures Treatment.** Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

**Payment.** Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

**Health care operations.** Your health information may be used as necessary to support the day-to-day activities and management of Reddy-Care Physical Therapy. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

**Law enforcement.** Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

**Public health reporting.** Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

**Business Associate Agreements:** To perform day-to-day functions of the practice, Reddy Care PT may disclose your information to outside parties (Belly, Google, Postcard Mania, etc) known as Business Associates. Reddy Care PT may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

**Other uses and disclosures require your authorization.** Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

**Additional Uses of Information Appointment reminders.** Your health information will be used by our staff to send you appointment reminders.

**Information about treatments.** Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

**Fund-raising.** Unless you request us not to, we will use your name and address to support our fund-raising efforts. If you do not want to participate in fund-raising efforts, please check off the following box.

☐ Please do not use my information for fund-raising purposes.

### Individual Rights

You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

### Reddy-Care Physical Therapy Duties.

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

**Right to Revise Privacy Practices.** As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

**Requests to Inspect Protected Health Information.** You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the facility office manager or the Director of Billing and Collections. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

### Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to

VP of Administration  
475 Northern Blvd  
Great Neck, NY 11021

