Patient Information Form

Patient Information

Last Name ______ First Name ______ MI ______ SSN ______

Address ______

Address2 ______ City ______ State ______ Zip ______

Home Phone ______ Work Phone ______ Cell Phone ______

Date of Birth ______ Gender ______ Marital Status ______ Email ______

Emergency Contact

Last Name ______ Relationship ______

First Name ______ Phone ______

Employer

Name ______ Phone ______

Address ______

Address2 ______ City ______ State ______ Zip ______

Problem

Problem Description ______ Date of Injury ______ Last Physician Visit / /

Referred By ______ Primary Care Physician ______

Latest Referral Information ______ Motor Vehicle Accident ______

That occurred in: ______

Notes: ______

Primary Insurance

Insurance ______ Deductible ______

ID ______ Max Benefit ______

Group # ______ CoInsurance ______

Subscriber

Name ______

Relationship ______

Date of Birth ______

Secondary Insurance

Insurance ______ Deductible ______

ID ______ Max Benefit ______

Group # ______ CoInsurance ______

Subscriber

Name ______

Relationship ______

Date of Birth ______

Tertiary Insurance

Insurance ______ Deductible ______

ID ______ Max Benefit ______

Group # ______ CoInsurance ______

Subscriber

Name ______

Relationship ______

Date of Birth ______

I authorize release of information requested by my insurance plan for payment.

I hereby consent and authorize all therapy treatments at Reddy-Care Physical & Occupational Therapy.

Signature: ______ Date: ______

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 therapy treatment.

Please be advised that Medicare **may not** cover out-patient therapy (Reddy-Care Physical & Occupational 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 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 therapy from Reddy-Care, **my therapy visits may not be covered.**

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

Initial:_________ Date: ________

Reddy-Care
PHYSICAL & OCCUPATIONAL THERAPY

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Cancellation Policy

When you are scheduled for a treatment session with a Reddy Care therapist who comes to your home, 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 notify our office of changes to your appointment, you will be charged a fee of $25. Your therapist will then have a large amount of time open, with no one to help and they will not be paid for this time. We care about your health and wellness and need you to be seen 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.

By initialing below I am stating that I understand this policy.

Initial: __________ Date: _________

MEDICAL HISTORY

Have you ever suffered from any of the following?

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

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_______

Please list any medications, or herbal supplements you are currently taking:

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:__________

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's Notice of Privacy Practices, as of the date indicated below.

HEALTH INFORMATION RELEASE

I authorize Reddy Care 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: ____

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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Patient Prescribed Treatment Plan & Diagnosis Verification

Patient Name: Date:

Referring Physician:

Referring Diagnosis:

Actual Diagnosis:

*********Prescribed therapy is ____________ times weekly********

Name of Therapist:____

- Please make sure the Actual DX and prescribed treatment are filled out

☐Check appt notes, tasks, or emails re: pt

☐Copy of ID

☐Copy of Ins card(s)- back and front

☐Copy of RX

☐Signed Consent to treat/Pt Info Form

☐Initialed Medical History Form

☐Initialed Pt Notice Form

☐Initialed HIPAA/Business Associates Form

☐Signed Cancellation policy Form

☐Initialed Important Info Tx Form

☐Signed Home Health Notice Form

☐Outcome measure filled out

☐ Signed ABN (if applicable)

☐ Power of Attorney (POA) (if applicable)

☐ Collect copay

☐ Collect any deductibles (if applicable)

☐ Give new patient hand out

☐ Verify pt info to be correct

☐ Schedule visit out 4 weeks in advance & enter into Clinicient

☐ Complete note within 24 hrs

☐ Emailed New Patient packet to HomeCareDocumentation@reddycare.net

Form Completed By: ____________________________

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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 & Occupational 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 may disclose your information to outside parties (Belly, Google, Postcard Mania, etc) known as Business Associates. Reddy Care 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 & Occupational 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
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Great Neck, NY 11021

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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. 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 losses it 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!

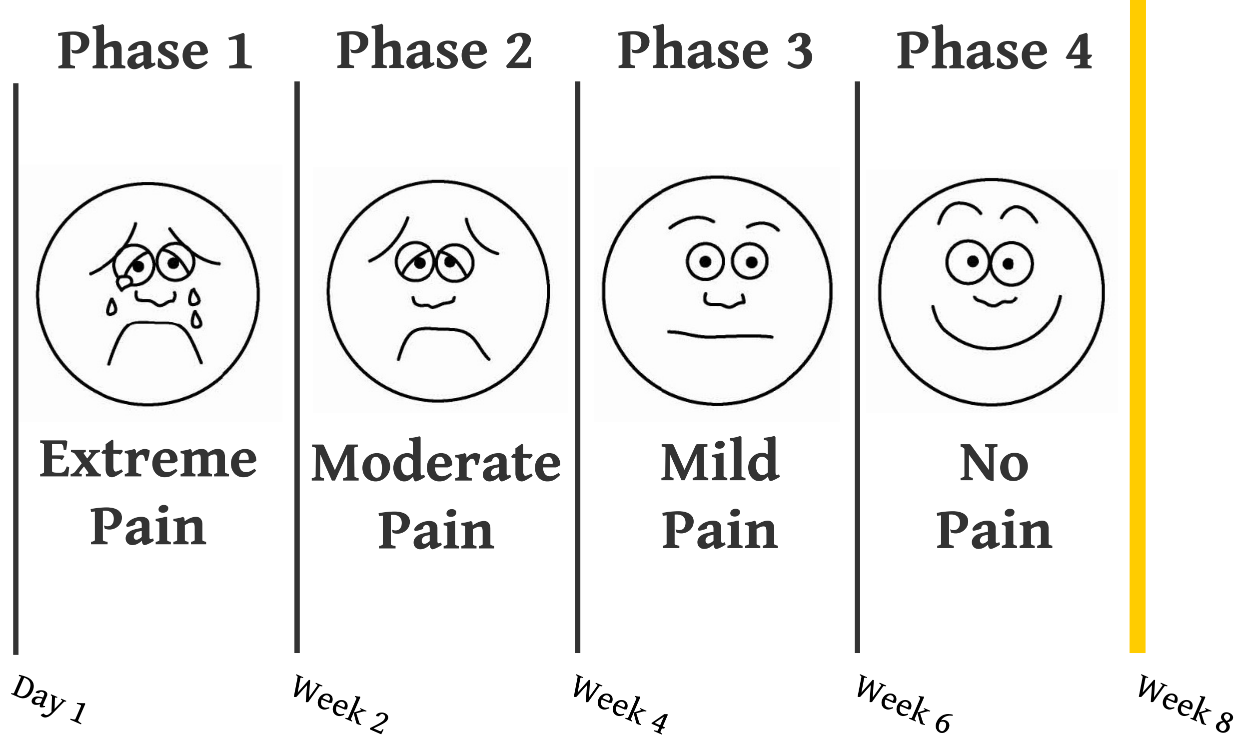
6. My doctor wants me to come in 2 times? We can call the doctor have him concur (which is generally successful) or if there is a condition that merits this, then 2 times a week may be required.

7. I don't want to see a different therapist? Our therapists are exceptionally trained and you may be surprise 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.

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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IMPORTANT INFORMATION REGARDING YOUR TREATMENT

Here at Reddy Care 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%.

3x/week: ★★★★★

You will have a higher percentage of improvement.

2x/week: ★★★☆☆

You will have a lower percentage of improvement.

1x/week: ★☆☆☆☆

You will have a minimal percentage of improvement.

The more committed you are to your therapy, at home and in the clinic, the better the results. Remember, 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