# WELCOME TO OUR CLINIC

## Registration Form

I chose clinic because/referred by: ❑ Dr._____ ❑Insurance Company ❑Hospital
❑Family ❑Friend ❑Close to home ❑Close to work ❑Yellow Pages ❑ Advertisement

### PATIENT INFORMATION

First Name: _____Middle:_____Last:_____Birth Date ____/_____/_____
Address: _____City: _____State: _____ Zip: _____Age: _____
Social Security Number _____-_____-_____ Sex: ❑Male ❑Female
Marital Status: Single Married Widowed Separated Divorced In a committed relationship
Are you employed? ❑ yes❑ no ❑retired Are you disabled? ❑yes ❑no Reason:_____
Occupation(former occupation if retired):_____
Employer:_____Employer Address:_____

### CONTACT INFORMATION

Please include only numbers we may call.
Home #:_____ Work #: _____ EXT. _____
Cell #:_____ Email*:_____
*If you supply us with an email you will automatically receive our clinic newsletter. You may opt out now or later if you wish.
My preferred method to reach me during the day is:home /cell /work /email

**In case of emergency, contact:**

Name: _____ Relationship:_____
Home #: _____ Work#:_____ Cell#_____
Primary Care Doctors Name:_____Phone #:_____

### CANCELLATION/NO SHOW POLICY

If you need to cancel an appointment and give more that 24 hours notice, you will not be charged. If you cancel or no show less than 24 hours in advance, you will be charged a cancellation fee of $25.00.

### ASSIGNMENT OF BENEFITS

I authorize the C.O.R.E. Physical Therapy Centers to use my name on any and all claims or documents that relate to health insurance benefits due to me and my dependents.
I authorize release of any information related to any claims to all my Insurance Companies or other relevant parties.
I understand that I am responsible for my bill and agree to pay all charges for services and items provided to me. I understand that I am responsible to pay co pays or deductibles.
I authorize payment of health benefits otherwise payable to me, directly to C.O.R.E. Physical Therapy Centers.
I permit a copy of this authorization to be used in place of the original.
This "Signature on File" is valid for one year from the date indicated below.

_____

Signature of Patient, Beneficiary or Guardian Date

388 Pleasant Street, Malden, MA 02148 Tel. 781-388-0012 Fax. 781-388-3312

## Health Insurance

Do you have health insurance? ❑yes ❑no If yes please fill out below:
Insurance Name:_____ Name of Insured: _____
DOB of Insured: _____ Relationship to insured:_____
Patient ID#:_____ Group#(if any): _____
Do you need a referral: ❑yes ❑no

## Responsible Party

If you DO NOT have health insurance, please fill out below if someone else is paying your bill:
Name of person responsible for payment of services: _____
Relationship to patient: _____Phone #:_____
Address:_____

## Auto Insurance Information

Is this injury related to an auto accident? ❑yes ❑no If yes please fill out below:
Date of Injury: ____/____/____
*Name of your Auto Insurance (or the car you where in):*
Auto insurance name: _____ Name of insured: _____
Policy #:_____Claim #/ID#: _____
Name of adjuster: _____ Phone #: _____
*Name of the Auto Insurance for the other car:*
Auto insurance name: _____ Name of insured: _____
Policy #:_____Claim #/ID#: _____
Name of adjuster: _____ Phone #: _____

## Workers Compensation

Is this injury related to a workers compensation claim? ❑yes ❑No If yes please fill out below:
Date of Injury: ____/____/____
Insurance Name:_____ Claim#:_____
Name of adjustor:_____Phone#:_____

## Attorney Information

Is there an Attorney involved? ❑yes ❑no If yes please fill out below:
Attorney's Name: _____Phone#: _____
Address: _____

## Authorization for Release of Information

I authorize the release of information during the course of my treatment at C.O.R.E. Physical Therapy including but not limited to medical records, verbal and written communications to my insurance company, employer, doctors, and third party payers.

I have received and read a copy of C.O.R.E. Physical Therapy Centers privacy procedures.

_____

Patient Signature Date

_____

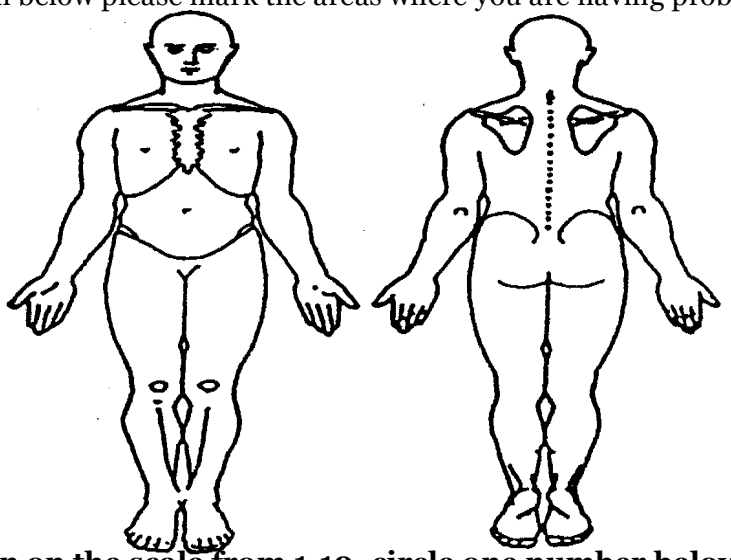
Person Responsible for Patient Date

**We thank you for filling out this form completely. We invite you to discuss with us any questions regarding our services. We believe in a friendly, mutual understanding between provider and patient. The therapist will review this information at you appointment.**

## CURRENT COMPLAINT

When did you injury occur? _____/_____/_____
What is your main complaint?_____
_____

Using the body diagram below please mark the areas where you are having problems:



**Please rate your pain on the scale from 1-10, circle one number below that describes your pain:**

**0 1 2 3 4 5 6 7 8 9 10**
**No Pain** **Uncomfortable** **Worst Pain Imaginable**

Has this or something similar happened in the past? ❑yes ❑no Explain past episodes:
_____
_____

## GENERAL HEALTH INFORMATION

What is the date of your last physical? _____
Do you smoke? ❑yes❑ no How much: _____If you quit, please note the year _____.
How many days per week do you drink beer, wine or other alcoholic beverages? _____ ❑none
Do you exercise beyond normal daily activities and chores? ❑yes❑ no
Are you currently taking supplements (vitamins ect…)? ❑yes❑ no Please list all supplements:
_____
Are you interested in learning more about which supplements you should be taking? ❑yes❑ no

## MEDICAL HISTORY

Please check (✓)if you have or had any of these symptoms or medical problems:

❑Heart Attack
❑Angina
❑Heart murmur
❑Heart problems/disease
❑High blood pressure
❑Circulation problems
❑High cholesterol
❑Migraines
❑Stroke
❑Cancer
❑Psychological Disorder
❑Arthritis
❑Osteoporosis
❑Broken bones/fractures
❑Blood Disorders/Anemia
❑Lung problems
❑Diabetes/high sugar
❑Hypoglycemia/low sugar

❑Head injury
❑Multiple sclerosis
❑Muscular dystrophy
❑Seizures/epilepsy
❑Developmental or growth problems
❑Liver Problems
❑Tuberculosis
❑Hepatitis
❑HIV
❑Kidney problems
❑Repeated infections
❑Ulcers/stomach problems
❑Skin diseases/problems
❑Depression
❑Alcohol/Drug abuse
❑Asthma
❑Artificial Bones Joints
❑Pacemaker

**For men only:**
❑Prostate disease/problems
❑Bacterial Prostatitis

**For women only:**
❑Currently pregnant
❑Endometriosis
❑Trouble with your period
❑Complicated pregnancies or deliveries
❑Other gynecological or obstetrical difficulties

Please list any past surgeries with dates and/or any other medical condition(s) not listed above:

_____

_____

## SYMPTOMS

Within the past year, please check (✓) if you have had any of the following symptoms:
Check all that apply

❑Chest pain
❑Heart palpitations
❑Cough hoarseness
❑Shortness of breath
❑Dizziness or blackouts
❑Coordination problems
❑Weakness in arms or legs
❑Loss of balance
❑Difficulty walking
❑Joint pain or swelling
❑Pain at night
❑Difficulty sleeping
❑Loss of appetite
❑Nausea/vomiting
❑Difficulty swallowing
❑Bowel problems(constipation/loss of control)
❑Weight loss/gain
❑Fever/chills/sweats
❑Headaches
❑Hearing problems
❑Vision Problem
❑Urinary problems(leakage/retention)

Other:_____

## OTHER CLINICAL TESTS

With in the past year, have you had any of the following tests? Check (✓)all that apply:

❑Angiogram
❑Arthroscopy
❑Biopsy
❑Blood Tests
❑Bone scan
❑Bronchoscopy
❑CT Scan/CAT Scan
❑Ultrasound
❑EEG (electroencephalogram)
❑EKG (electrocardiogram)
❑EMG (electromyogram)
❑Mammogram
❑MRI
❑Myelogram
❑Nerve Conduction Velocity
❑Pap Smear
❑Pulmonary Function Test
❑Chest X-ray
❑Spinal Tap
❑Stool Test
❑Stress Test (Treadmill or Bike

****Please* list *all* of the medications that you are taking(over the counter and prescribed):**

_____

_____

Please list anything/medication/substance that you may be **allergic** to: _____

_____

## SIGNATURE

I certify that the above information is correct to the best of my knowledge. I will not hold my therapist or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____

Patient Signature Date

388 Pleasant Street, Malden, MA 02148 Tel. 781-388-0012 Fax. 781-388-3312

# C.O.R.E. Physical Therapy Centers
## NOTICE OF PRIVACY PRACTICES

**QUESTIONS AND COMPLAINTS**

If you have and questions about this notice or if you think that we may have violated your privacy rights, please contact by phone or in writing:

Elizabeth Canoni PT, MS, DPT

388 Pleasant Street, Suite 203 Malden, MA 02148 Phone: 781-388-0012

You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint and we will not retaliate in any way if you choose to file a complaint. We can also furnish complaint forms to you at no cost.

**ACKNOWLEDGEMENT**

**I have obtained the Notice of Privacy Practices and have had the opportunity to review it.**

_____

Signature of Patient or Legal Guardian Date

***For office use only:***

❒ The patient has downloaded the information from our website and has reviewed it.

❒ Attempted to obtain written acknowledgement of receipt of our practices but unable because:

_____

Date: _____ Initials: _____

# C.O.R.E. Physical Therapy Centers
## 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.*

**This notice takes effect on April 14, 2005 and remains in effect until we replace it.**

**Our Pledge Regarding Medical Information**

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at Allied Physical Therapy. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

**Our Legal Duty**

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding this information.
3. Follow the terms of the notice that is now in effect.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before that changes.

Notice of Change to Privacy Practices:

1. Before we make and important change in our privacy practices, we will change this notice and make the new notice available upon request.

**Use and Disclosure of Your Medical Information**

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. *We will not use or disclose your medical information for any purpose not listed below, without your specific authorization. Any specific written authorization you provide may be revoked at any time by writing to us.*

*FOR TREATMENT:* We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people taking care of you. We may also share medical information about your to your other health care providers to assist them in treating you.

*FOR PAYMENT:* We may use and disclose your medical information for payment purposes.

*FOR THE FACILITY:* We may use and disclose your medical information for our facilities operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting certificates, licenses and credentials needed to serve you.

*ADDITIONAL USES AND DISCLOSURES:* In addition to using and disclosing your medical information for treatment, payment and for use by our facility, we may use and disclose medical information for the following purposes.

Notification: Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition or death. If you are present we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

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Legal Compliance: We may disclose medical information to comply with applicable law. For example to respond to regulatory authorities responsible for oversight of government benefit programs or courts in the course of judicial or administrative proceedings: and to law enforcement officials during an investigation. We may also, as required by law disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or a possible victim of other crimes.

**YOUR INDIVIDUAL RIGHTS**

You Have a Right to:

1. Look at or get copies of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you $.10 for each page, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for full explanation of our fee structure.
2. Receive a list of all the times we or our business associated shared your medical information for purposes other that treatment, payment, and facility use and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with your about your medical information by different means or to different locations. Your request must be made in writing to the contact person listed at the end of this notice.
5. Request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information that you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.

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