ECRC
PHYSICAL THERAPY

PLEASE KEEP THIS COVERSHEET REGARDING OFFICE POLICIES/PROCEDURES FOR YOUR RECORDS.

ECRC Physical Therapy - New Patient Information

Welcome to ECRC Physical Therapy! We appreciate the opportunity to guide and assist you towards better health. Here are some guidelines to help make your appointments run smoothly and help us provide you with the care you desire:

● If you have a written referral or prescription from a provider for Physical Therapy, please bring that with you to the first appointment as well as any other information your physician provided *(for example: Xray, CT or MRI reports, operation notes and/or doctor's office notes, surgery protocols, etc.).*

● Fill out the attached "New Patient Packet" (if convenient, you may pick this up at any of our offices prior to your appointment. If you are unable to complete the packet beforehand, please arrive at least 20 minutes prior to your appointment time, to allow ample time for completion. We can assist if you have any questions regarding these forms.

● Your initial evaluation (IE) will take approximately one hour. During this visit, you will be provided with a list of follow-up visits (which typically are scheduled for approximately 30 minutes, based on any time restrictions you shared with us previously.) We ask that you take this home and review this list thoroughly. Please let us know if you are unable to make any of these visits. *Please note that there may be some scheduling conflicts, we will do our best to meet your time requirements*. If there aren't convenient times available, we can place you on our waitlist and contact you with any potential openings.

● We understand that you may be required to miss an appointment due to unforeseen circumstances. However, missing an appointment without prior notification (no call or &/or no reasoning for missing the appointment(s), this gravely affects our ability to help you resolve your condition. Additionally, this doesn't allow us to utilize your appointment time for patients who require physical therapy.

● **Our goal is to help you resolve your condition, so your attendance is critical**. If you know you will arrive more than ten (10) minutes after your appointment, please call our office to let us know. If you arrive more than ten (10) minutes after your appointment time, we may have to reschedule, (and this would be considered a late cancel.)

A no-show/late cancellation fee of $50.00 may be assessed if you fail to arrive for a scheduled appointment and have not provided at least 24 hours' advanced notice. -- This fee will not be paid by your insurance and will be collected at your next scheduled visit. When time permits, we make reminder calls (or emails) the business day prior to your appointment as a courtesy to you. If you do not receive a reminder, the above policy will remain in effect.

INSURANCE DISCLAIMER:

●We accept a wide range of insurance carriers. We cannot guarantee payment of insurance for any treatment rendered. Any estimate provided regarding the cost of treatment is **strictly** an estimate. We make every attempt to communicate any potential financial responsibility you may incur. However, it is your responsibility to be familiar with your benefit details. We encourage you to contact your insurance company directly with any questions or concerns regarding these benefits. ***(Please be advised that any estimates provided are not guaranteed payment, and your insurance company gets the final decision.)***

● Your cost share, if any, is due at the time of service. Please come prepared to pay your financial portion of the Physical Therapy benefit. Under certain circumstances, for example high deductibles or no insurance coverage, we do offer individualized payment plans, please contact our Billing Department to discuss your options.

LISBON - 2B Lee Road, Lisbon, CT 06351 | Ph: 860-376-2564 | Fax: 860-376-4812
DAYVILLE - 165 Hartford Pike, Dayville, CT 06241 | Ph: 860-779-0150 | Fax: 860-774-2371
[Billing Dept: 860-376-5527]

NAME: _____ | DOB: _____ | DATE: _____

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Consent for Care and Treatment

I, the undersigned, agree and give my consent for ECRC to furnish physical therapy care and treatment as considered necessary and proper in the diagnosis and treatment of my illness or injury.

Benefit Assignment / Release of Information:

I request that payment of authorized benefits be made on my behalf to ECRC for physical therapy services furnished to me. I authorize any holder of medical information about me to release to my insurance(s) (the "Centers of Medicare and Medicaid Services", and its agents for Medicare patients) any information needed to determine these benefits or benefits for related services. ***We require that you provide your insurance information to us prior to your initial visit. This includes primary, secondary, and tertiary payers (if applicable.)***

Cancellation / No Show Policy:

If you need to cancel/reschedule your appointment, please provide at least 24 hours' notice to allow us to offer your appointment time to other patients.

A no-show/late cancellation fee of $50.00 may be assessed if you fail to arrive for a scheduled appointment and have not provided at least 24 hours' advanced notice. -- This fee will not be paid by your insurance and will be collected at your next scheduled visit. When time permits, we make reminder calls (or emails) the business day prior to your appointment as a courtesy to you. If you do not receive a reminder, the policy will remain in effect.

Agreement to Pay:

ECRC will bill your insurance company solely as a courtesy to you. All fees for services provided are your responsibility. We require you to pay your estimated cost share, as specified by your insurance carrier, for each visit at the time of service. We will then bill your insurance payer, if there is any remaining amount due, we will bill you. We encourage you to contact your insurance carrier to make sure you as a member are provided with the same financial responsibility details as ECRC.

I understand and agree that if I fail to make regular payments as described above, I will be responsible for all costs of collection monies owed, including our costs, collection agency fees and/or court and attorney fees.

E-Mail Address Consent:

If you would like ECRC to email your appointment reminders (the day prior to your appointment) or information pertaining to your health or any services we provide, please provide your email below:

E-Mail: _____

I have read, understand, and agree to the above conditions. I understand my full responsibility for the payment of my account.

_____ _____

Signature of Patient, Guarantor or Legal Representative **Date**

NAME: _____ | DOB: _____

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Authorization to Release Medical Information, Emergency Contacts and Acknowledgement of Privacy Practices

Authorization to Release Medical Information:
I hereby authorize ECRC to disclose my identifiable information to the following: *(This is where you will add any additional person(s), provider(s), attorney(s), etc that you grant permission for us to speak with/schedule/reschedule and/or regarding your appointments)* *(note: please indicate "n/a" on line 1 below, if you don't request anyone listed.)*

1. _____
2. _____
3. _____

I understand that if the person or entity receiving this information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above could be re-disclosed by such a person or entity and will likely no longer be protected by federal privacy regulations. I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the ECRC staff. I understand that the revocation will not apply to the information that has already been released in response to this authorization. I understand this revocation does not apply to my insurance company as the law provides my insurer with the right to contest a claim under my policy.

Emergency Contact:

_____ _____
Name/Relationship: **Contact Number:**

Acknowledgement of Privacy Practices:
I hereby acknowledge that I have reviewed a copy of ECRC's Notice of Privacy Practices (posted in the waiting room). I understand that if I have further questions or concerns, I may contact ECRC, Kristi Hachey, 2B Lee Road, Lisbon, CT 06351; (860) 376-2564. I also understand that I am entitled to receive updates, upon request, if the Notice of Privacy is amended or changed in a material way.

_____ _____
Signature of Patient, Guarantor or Legal Representative: **Date:**

NAME: _____ | DOB: _____

Type of Injury / Previous Care

Please complete the following information:

The physical therapy that is requested is due to: [check all that apply]	
MUST ACKNOWLEDGE:	☐ Work-Related Injury; If so, have you filed a Worker's Compensation claim? ☐No ☐Yes | Date of Injury: _____
	☐ Not Worker's Compensation
	☐ Not a motor vehicle accident

For Medicare patients: Medicare will NOT reimburse ECRC for outpatient physical therapy services if you are actively enrolled with a **Home Health Care Agency.** If Medicare denies payment for services based on the above, **member will be responsible for payment.**

I have been treated for Physical Therapy / Occupational Therapy / Speech Therapy and/ or Chiropractic this year: * THIS INCLUDES ANY HOME THERAPY*****

☐No ☐Yes, # of visits: _____ | Dates Treated AND/OR # OF VISITS: _____

Note: Most insurance plans with a combined benefit of physical, occupational, speech and chiropractic therapies will not cover more than one therapy on the same day. If your insurance denies for this reason, you will be financially responsible for any cost.

I request payment of authorized benefits be made on my behalf of ECRC for any services furnished to me by ECRC staff. I understand my signature requests that payment be made, and I authorize the release of my medical information necessary to process this claim.

_____ _____

Signature of Patient, Guarantor or Legal Representative **Date**

NAME: _____ | DOB: _____ | DATE: _____

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PERSONAL MEDICAL HISTORY

To help us treat you as a whole person instead of just a body part, kindly fill out the information on the following pages. Thank you.

Please check if you have been diagnosed with any of these by a doctor in the past:

[ ] Diabetes / High Blood Sugar	[ ] Cancer	[ ] Broken Bone / Fracture
[ ] Hypoglycemia / Low Blood Sugar	[ ] Depression	[ ] Osteoporosis
[ ] Ulcer / GERD / Stomach Problems	[ ] Osteoarthritis	[ ] Kidney Problems
[ ] Rheumatoid Arthritis	[ ] Lung Problems	[ ] Multiple Sclerosis
[ ] Circulation / Vascular Problems	[ ] Stroke	[ ] Skin Diseases
[ ] Head Injury	[ ] Allergies	[ ] Hepatitis
[ ] Asthma	[ ] Seizures / Epilepsy	[ ] Blood Disorder
[ ] Parkinson's Disease	[ ] Anemia	[ ] Repeated Infections
[ ] Heart Problems	[ ] High Blood Pressure	[ ] Thyroid Problems

Number of falls in the last year: _____

In the last year, have you had any of the following? Please check all that apply:

[ ] Chest Pain	[ ] Loss of Balance	[ ] Tingling
[ ] Shortness of Breath	[ ] Difficulty Sleeping	[ ] Fever / Chills / Sweats
[ ] Weakness "in.-Arms or Legs	[ ] Nausea / Vomiting (not Flu)	[ ] Vision Problems
[ ] Joint Pain or swelling	[ ] Weight Loss/ Gain	[ ] Hoarseness
[ ] Difficulty Swallowing	[ ] Hearing Problems	[ ] Pain at Night
[ ] Urinary Problems	[ ] Cough	[ ] Numbness
[ ] Headaches	[ ] Coordination Problems	[ ] Bowel Problems
[ ] Heart Palpitations	[ ] Difficulty Walking	[ ] _____
[ ] Dizziness	[ ] Loss of Appetite	

For <u>MEN</u> only:

Have you ever been diagnosed with prostate disease?	[ ] No	[ ] Yes
Do you have difficulty beginning to urinate?	[ ] No	[ ] Yes
Do you have difficulty continuing to urinate?	[ ] No	[ ] Yes
Do you have pain with urination?	[ ] No	[ ] Yes

For <u>WOMEN</u> only:

Have you seen a doctor for any pelvic problems?	[ ] No	[ ] Yes
Are you pregnant or trying?	[ ] No	[ ] Yes
When was your last Pap Smear:_____		last Breast Exam:_____
Do you ever have any urinary leakage?	[ ] No	[ ] Yes

Surgery (for <u>ALL</u>):

Have you ever had surgery? [ ] No [ ] Yes _____

if yes, please list approximate date(s): _____

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Are you currently seeing anyone else for the problem that brought you here? Please check all that apply:

[ ] Acupuncturist	[ ] Podiatrist	[ ] Dentist
[ ] Neurologist	[ ] Primary Care Physician	[ ] Cardiologist
[ ] Obstetrician I Gynecologist	[ ] Rheumatologist	[ ] Orthopedist
[ ] Occupational Therapist	[ ] Pediatrician	[ ] Osteopath
[ ] Massage Therapist	[ ] Chiropractor	[ ] Other _____

Are you allergic to latex? [ ] No [ ] Yes
Are you allergic to oils, lotions, or creams? [ ] No [ ] Yes
Do you smoke or chew tobacco? [ ] No [ ] Yes
if yes, Packs per day: _____ For how long: _____
How many days each week do you drink alcohol? _____
If 1 drink equals 1 beer or 1 glass of wine, how much do you drink in an average sitting?_____
How much caffeinated coffee [or caffeine-containing beverages] do you drink each day?_____
Do you ever feel unsafe at home or has anyone hit you or tried to hit you in any way? [ ]No [ ]Yes

Anything else we should know about?

_____
_____
_____
_____

Medications:
Current medications (prescription and over the counter) with dosages:

_____
_____
_____
_____
_____
_____
_____

NAME: _____ | DOB: _____

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SOCIAL:

With whom do you live? [check ALL that apply]

[ ] Alone
[ ] Spouse / Significant Other
[ ] Child
[ ] Spouse / and Other(s): _____

Does your home have: [check ALL that apply]

[ ] Stairs, no railing
[ ] Uneven Terrain
[ ] Obstacles (please list below)
[ ] Assistive Devices in Bathroom (please list below)
[ ] Stairs, Railing
[ ] Scatter Rugs
[ ] Elevator
[ ] Ramps

_____

_____

Do you use: [check ALL that apply]

[ ] Glasses / Contact Lenses
[ ] Hearing Aids
[ ] Any Assistive Devices:_____
[ ] Other:_____

Do you have difficulty with: [check ALL that apply]

[ ] Moving in Bed
[ ] Walking on Stairs
[ ] Getting Dressed
[ ] Toileting
[ ] Preparing Meals
[ ] Moving from Bed to Chair
[ ] Walking on Ramps/Hills
[ ] Bathing
[ ] Household Chores
[ ] Driving
[ ] Walking on Level Ground
[ ] Walking on Uneven Terrain
[ ] Eating
[ ] Shopping
[ ] Participating in Sports

FAMILY HISTORY: [check ALL that apply]

	Mother:	Father:	Brother:	Sister:	Grandparent(s):	Other:
Heart Disease:						
High Blood Pressure:						
Stroke:						
Diabetes:						
Cancer:						
Osteoporosis:						
Psychological:						
Other:						

The above is true to the best of my knowledge [ ]No [ ]Yes

NAME: _____ | DOB: _____ | DATE: _____

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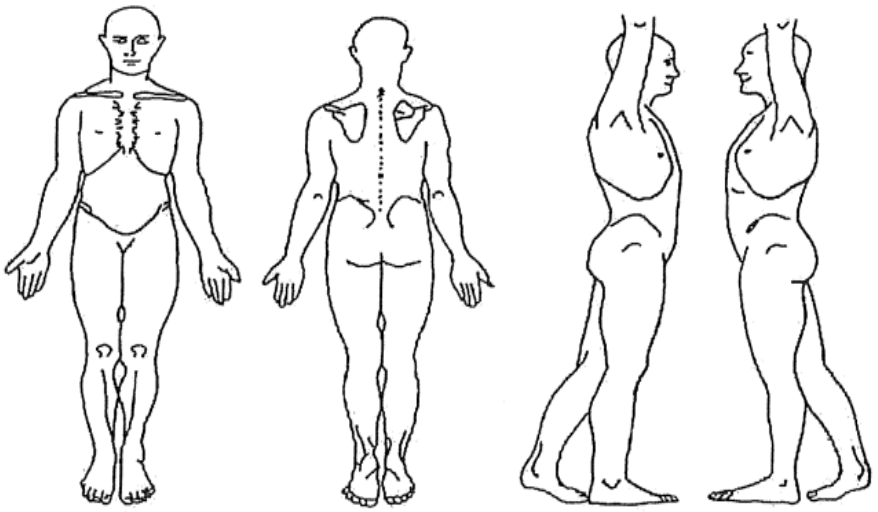
System Questionnaire



Please circle/mark on the below image the location(s) of your pain:

Does your pain come and go? [ ]No [ ]Yes

Using the below scale, place a B, W and A over the number below regarding the INTENSITY of your pain:

1. In the last week, **when you were feeling your BEST (B**), how low was your pain?
2. In the last week, **when you were feeling your WORST (W),** how high was your pain?
3. What has been your **AVERAGE (A)** pain over the last 24 hours?