REGIONAL REHAB ASSOCIATES, PA DBA

JAFFE SPORTS MEDICINE
PHYSICAL THERAPY | PAIN MANAGEMENT

PATIENT REGISTRATION FORM _____ **NEW** _____ **UPDATED** **DATE**_____

Last Name:_____**First Name:**_____**MI:**_____

Date of Birth:_____ **Marital Status: M / S / D / W** **Sex: M / F**

Primary Address:_____

City:_____**State:**_____**Zip:**_____

Secondary Address:_____

City:_____**State:**_____**Zip:**_____

E-Mail Address:_____**Social Security Number:**_____

Employer:_____**Phone Number:**_____

Primary Care Physician:_____**Phone Number:**_____

Emergency Contact:_____**Phone Number:**_____

Is Injury related to: **Work: Y / N** **Accident: Y / N** **Litigation: Y / N**

Primary Health Insurance: **ID #**_____

Secondary Health Insurance: **ID #**_____

Had Physical Therapy anywhere this year: **Y / N** **If so where:**_____

Auto Related:

Auto Insurance:_____**Claim #**_____**Date/Accident:**_____

Adjustor Name:_____**Phone Number:**_____ **Attorney: Y / N**

Work Comp Related:

Insurance:_____**ID #**_____

Adjustor Name:_____**Phone Number:**_____

PATIENT NAME:_____

PATIENT SIGNATURE:_____

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FIRST NAME: _____LAST NAME: _____DATE: _____

GENDER: _____DOB: _____ AGE: _____ RACE: _____

OCCUPATION: _____ REFERRED BY: _____

REASON FOR VISIT:_____

DATE SYMPTOMS BEGAN: _____

HOW SEVERE IS YOUR PAIN?

- ☐ 1 (no pain)
- ☐ 2 (tolerate without medication)
- ☐ 3-4 (tell someone about my pain, take aspirin or motrin)
- ☐ 5-6 (mild narcotic e.g. Tylenol)
- ☐ 7-8 (go to E.R., take strong narcotics)
- ☐ 9-10 (admission to hospital for pain control)

WHAT TREATMENTS HAVE YOU TRIED TO HELP YOUR CURRENT CONDITION/INJURY?

- ☐ THERAPY Type of therapy:_____ Location:_____
- ☐ INJECTIONS Type of Injections:_____ Location:_____
- ☐ MEDICATIONS Type of Medication:_____
- ☐ SURGERY Type of Surgery:_____ Year:_____

WHAT STUDIES HAVE YOU HAD TO DIAGNOSE YOUR CONDITION/INJURY?

- ☐ X-RAY Location:_____ Year:_____
- ☐ CT SCAN Location:_____ Year:_____
- ☐ MRI Location:_____ Year:_____
- ☐ EMG/NCV Location:_____ Year:_____

DO YOU HAVE ANY NUMBNESS OR TINGLING IN YOUR ARMS/HANDS/LEGS/FEET? YES NO

IS THIS THE RESULT OF AN:

- ☐ AUTO
- ☐ WORK INJURY
- ☐ SLIP AND/OR FALL

IF YES, WHAT IS THE DATE OF INJURY? _____

PLEASE LIST ANY AND/OR ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

PLEASE LIST ANY KNOWN ALLERGIES TO MEDICATIONS, FOOD, OR OTHER SUBSTANCES?

_____ _____
_____ _____

NAME, LOCATION, and PHONE NUMBER OF YOUR PHARMACY:

_____

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PLEASE LIST PAST SURGURIES:

_____ _____
_____ _____
_____ _____

DO YOU HAVE (HAVE HAD) ANY OF THE FOLLOWING:

- ☐ HEART DISEASE
- ☐ HIGH BLOOD PRESSURE
- ☐ DIABETES (if yes: Insulin dependent _____ not insulin dependent _____)
- ☐ ASTHMA/COPD
- ☐ CANCER
- ☐ SEIZURES
- ☐ ANEMIA
- ☐ ARTHRITIS (if yes: Rheumatoid _____ Osteoarthritis _____)
- ☐ KIDNEY DISEASE
- ☐ HEPATITIS/LIVER DISEASE
- ☐ HEADACHES
- ☐ TUBERCULOSIS
- ☐ THYROID DISEASE
- ☐ STROKE
- ☐ ULCERS
- ☐ PSYCHOLOGICAL DISORDER (PLEASE LIST _____)

ANY CHANCE OF PREGNANCY? _____

FAMILY MEDICAL HISTORY (PLEASE CHECK IF YOUR FAMILY HAS ANY OF THE FOLLOWING):

☐ HEART DISEASE	FAMILY MEMBER:_____
☐ CANCER	FAMILY MEMBER:_____
☐ DIABETES	FAMILY MEMBER:_____
☐ LIVER DISEASE	FAMILY MEMBER:_____
☐ CHRONIC PAIN	FAMILY MEMBER:_____
☐ THYROID DISEASE	FAMILY MEMBER:_____
☐ ARTHRITIS	FAMILY MEMBER:_____
☐ KIDNEY DISEASE	FAMILY MEMBER:_____
☐ LUNG DISEASE	FAMILY MEMBER:_____
☐ OTHER:_____	FAMILY MEMBER:_____

SOCIAL HISTORY (DO ANY OF THE FOLLOWING PERTAIN TO YOU? PLEASE CHECK ACCORDINGLY)

☐ ALCOHOL CONSUMPTION	NO	YES	(how much) _____
☐ CIGARETTE SMOKING	NO	YES	(packs per day) _____
☐ RECREATIONAL DRUG USE	NO	YES	_____

This is a confidential record of your history tat will be kept in the office. Information obtained will not be released to any person except who you have authorized our office to release to. To the best of my knowledge, the information on this form has been accurately answered. I understand providing inaccurate information can be dangerous to my (my child's) health. It is my responsibility to inform this office of any changes in my (my child's) medical status. I also authorize the medical staff to perform the necessary health care services that I (my child) may need.

PATIENT/GUARDIAN'S SIGNATURE :_____

PRINT NAME: _____

PHYSICIAN SIGNATURE:_____ **DATE:** _____

(I have reviewed this information with this patient)

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HIPPA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT & AUTHORIZATION

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) requires us to provide you with our notice of Privacy Practices which explains our privacy practices and how we may legally use and disclose your Protected Health Information (PHI). In order to protect your privacy and confidentiality, we ask you authorize when, and to whom, protected health information can be released.

MAY WE LEAVE A DETAILED MESSAGE ON YOUR HOME ANSWERING MACHINE? **YES** **NO**

MAY WE PHONE YOU AT WORK AND LEAVE A MESSAGE TO CALL OUR OFFICE BACK? **YES** **NO**

DO WE HAVE YOUR PERMISSION TO TALK TO FAMILY MEMBERS OR OTHER INDIVIDUALS? **YES** **NO**

IF YES, PLEASE PROVIDE THE NAMES, PHONE NUMBERS, & RELATIONS TO YOU:

NAME:_____**PHONE:**_____**RELATION:**_____

NAME:_____**PHONE:**_____**RELATION:**_____

NAME:_____**PHONE:**_____**RELATION:**_____

ALL BENIGN TEST RESULTS ARE COMMUNICATED TO THE PATIENT THROUGH STANDARD MAIL, UNLESS OTHERWISE SPECIFIED, THESE RESULTS WILL BE SENT TO YOUR MAILING ADDRESS. THEREFORE, PLEASE NOTIFY OUR OFFICE IF YOU WANT TO RECEIVE YOUR RESULTS AT AN ALERTNATE LOCATION.

By signing this form, I acknowledge that I have received a copy of Regional Rehab Associates, PA dba Jaffe Sports Medicine and Rehabilitation Notice of Privacy Practices and have been given the opportunity to ask questions. A copy of this content will be included in my chart for future reference.

PATIENT NAME:_____**DATE:**_____

PATIENT SIGNATURE:_____**DATE:**_____

REGIONAL REHAB ASSOCIATES, PA DBA

150 TAMIAMI TRAIL NORTH
NAPLES, FL 34102
239-331-8551 FAX 239-331-8560

MEDICAL RECORDS RELEASE

Patient Name:_____ **Date of Birth:**_____

Reason for Request:_____

Records Requested: _____ **All Records**

_____ **Operative Report (s)**

_____ **Specific date (s) of service**

_____ **MRI / X-ray / CT Scan**

Release records to:

_____ **REGIONAL REHAB ASSOCIATES PA, dba JAFFE SPORTS MEDICINE- PLEASE MAIL TO THE ABOVE ADDRESS OR FAX TO 239-331-8560**

_____ **OTHER (PLEASE PROVIDE NAME, ADDRESS, PHONE, AND FAX)**

_____
_____
_____

_____ **PATIENT ( ) MAIL ( ) PICK UP**

PATIENT NAME:_____**DATE:**_____

PATIENT SIGNATURE:_____**DATE:**_____

REGIONAL REHAB ASSOCIATES, PA DBA

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FINANCIAL POLICY

Medicare Part B

Regional Rehab Associates, PA dba Jaffe Sports Medicine is a Medicare part B provider. We will accept assignment on all Medicare Part b claims. By accepting assignment, we agree to adjust your charges to reflect the Medicare approved amount. However, Medicare only pays 80% of the approved amount, and the remaining 20% is your responsibility. If you have supplemental insurance, we will bill your supplemental insurance the 20% balance. If there is any remaining after Medicare and the supplemental insurance payment, it is the patient's responsibility.

Private Health Insurance

As a courtesy to you, we will file claims with your insurance company. Please understand, however, that your insurance reflects a contract between you and the insurance company, not Regional Rehab Associates, PA dba Jaffe Sports Medicine. You, as the patient are ultimately responsible for your bill. Patients without health insurance will be expected to pay at the time of service or to make payment arrangements with the billing office. We may also collect at the time of service, any fee that will be paid directly to you from the insurance company, as well as any co-pay or deductible amounts..

Managed Care Networks

Dr. Peter Jaffe is a participating provider with Community Health Partners and Florida Blue formerly known as Blue Cross Blue Shield of Florida. We will file claims to Florida Blue and those insurers or organizations with whom Community Health Partners is contracted. Co-pays and co-insurance and/or deductible will be due at the time of service.

Usual, Reasonable and Customary

Some insurance carriers have established "usual", "reasonable", and "customary" maximum amounts that they will pay for specific procedures. These amounts may vary with each insurance company. Any amount considered in excess of the "usual", "reasonable", and "customary" amount this is not paid by the insurance company, becomes the patient's responsibility.

Non covered services

Not all services are covered by all insurance health plans. Some services may be covered by your specific or individual policy. **Services not covered or considered payable by the Insurance Company becomes the patient's responsibility.**

I have read and fully understand this information and I agree to accept financial responsibility for the unpaid balance of the accounts in the event the following authorization is insufficient to liquidate the account.

I request the payment of authorized Medicare benefits be made on behalf of Regional Rehab Associates, PA dba Jaffe Sports Medicine and Rehabilitation, for any services rendered.

I hereby assign and transfer any insurance benefit due to me for the professional services that I have received, to Regional Rehab Associates, PA dba Jaffe Sports Medicine and Rehabilitation.

I authorize the release of any medical information necessary to process insurance claims.

PATIENT SIGNATURE:_____ **DATE:**_____

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Consent for the Purpose of Treatment, Payment, or Health Care Operations

I consent to the use or disclosure of my protected health information by Regional Rehab Associates, PA dba Jaffe Sports Medicine and Rehabilitation for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Regional Rehab Associates, PA dba Jaffe Sports Medicine and Rehabilitation.

I understand that diagnosis or treatment of me by Regional Rehab Associates, PA dba Jaffe Sports Medicine and Rehabilitation may be continued upon my consent as evidence by my signature of this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations. Regional Rehab Associates, PA dba Jaffe Sports Medicine and Rehabilitation is not required to agree to the restrictions that I may request. However, if Regional Rehab Associates, PA dba Jaffe Sports Medicine and Rehabilitation agrees to a request restriction that I request, the restriction is binding on the practice.

I have the right to revoke this Consent, in writing, at any time, except to the extent that Regional Rehab Associates, PA dba Jaffe Sports Medicine and Rehabilitation has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information collected from me and collected or received by the physician, another health care provider, a health plan, my employer, or a health care clearing house. This protected information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review the Notice of Privacy Practices, which has been offered or provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment, of my bills or the performance of health care operations.

A summary of the Notice of Privacy Practices is also posted in the waiting room.

Regional Rehab Associates, PA dba Jaffe Sports Medicine and Rehabilitation reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised Notice of Privacy Practices by contacting the Designated Privacy Officer at 239-254-7778.

Patient Name:_____

Patient/Representative Signature:_____

Name of Patient/Representative (please print)_____

Date:_____

Employee Initial: _____

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Cancellation and Missed Appointment Policy

Our goal is to provide quality individualized medical care in a timely manner. "No-shows", and late cancellations inconvenience those individuals who need access to medical care in a timely manner. We would like to remind you of our office policy regarding missed appointments. This policy enables us to better utilize available appointments for our patients in need of medical care.

Cancellation of an Appointment

In order to be respectful of the medical needs of other patients, please be courteous and call Jaffe Sports Medicine promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Failure to provide 24 hour notice of cancellation will result in a ***$50 cancellation fee.*** Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

How to Cancel Your Appointment

To cancel appointments, please call 239-254-7778 (North Naples location) or 239-331-8551 (Downtown location). If you do not reach the receptionist you may leave a detailed message on the voicemail. If you would like to reschedule your appointment, please leave your phone number. We will return your call and give you the next available appointment time.
Late Cancellations: A late cancellation is considered when a patient fails to cancel their scheduled appointment with a 24 hour advance notice.

No Show Policy

A "no-show" is when a patient misses their scheduled appointment without cancelling it in an adequate manner. A failure to be present at the time of a scheduled appointment will be recorded in your medical record as a "no-show". A missed appointment results in a ***$50 missed appointment fee.***

The $50 cancellation fee will be waived if any canceled, missed, or no show appointments are rescheduled and attended within the same business week

PATIENT NAME:_____**DATE:**_____

PATIENT SIGNATURE:_____**DATE:**_____