



7117 Congdon Rd. #200 Fort Myers, FL 33908  
239-703-7096

PATIENT REGISTRATION FORM \_\_\_\_\_ NEW \_\_\_\_\_ UPDATED DATE \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Marital Status: M / S / D / W Sex: M / F

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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):**

- |  |                      |
|--|----------------------|
| <input type="checkbox"/> HEART DISEASE   | FAMILY MEMBER: _____ |
| <input type="checkbox"/> CANCER          | FAMILY MEMBER: _____ |
| <input type="checkbox"/> DIABETES        | FAMILY MEMBER: _____ |
| <input type="checkbox"/> LIVER DISEASE   | FAMILY MEMBER: _____ |
| <input type="checkbox"/> CHRONIC PAIN    | FAMILY MEMBER: _____ |
| <input type="checkbox"/> THYROID DISEASE | FAMILY MEMBER: _____ |
| <input type="checkbox"/> ARTHRITIS       | FAMILY MEMBER: _____ |
| <input type="checkbox"/> KIDNEY DISEASE  | FAMILY MEMBER: _____ |
| <input type="checkbox"/> LUNG DISEASE    | FAMILY MEMBER: _____ |
| <input type="checkbox"/> OTHER: _____    | FAMILY MEMBER: _____ |

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

- |  |    |     |                       |
|--|----|-----|-----------------------|
| <input type="checkbox"/> ALCOHOL CONSUMPTION   | NO | YES | (how much) _____      |
| <input type="checkbox"/> CIGARETTE SMOKING     | NO | YES | (packs per day) _____ |
| <input type="checkbox"/> RECREATIONAL DRUG USE | NO | YES | _____                 |

This is a confidential record of your history that 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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7117 Congdon Rd. #100  
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239-703-7096 FAX 855-959-1692

**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 855-959-1692

\_\_\_\_\_ OTHER (PLEASE PROVIDE NAME, ADDRESS, PHONE, AND FAX)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ PATIENT ( ) MAIL ( ) PICK UP

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



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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 (please print):** \_\_\_\_\_

**Patient/Representative Signature:** \_\_\_\_\_

**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: \_\_\_\_\_