REGIONAL REHAB ASSOCIATES, PA DBA

PATIENT REGISTRATION FORM _______ **NEW** ______ **UPDATED** **DATE** ________________

Last Name: ____**First Name:** ____________________________________**MI:**______________

Date of Birth: ____ **Social Security Number:** ____

Marital Status: M / S / D / W **Sex:** M / F

Primary Address: ____

City: ____**State:**______________________________**Zip:**___________________________

Home Phone: ___________________________**Cell Phone:** __________________________**Work Phone:** _______________________________

Northern Address: ____

City: ____**State:**______________________________**Zip:**___________________________

E-Mail Address: ____

Employer: ____**Phone Number:** _______________________________

Primary Care Physician: ____**Phone Number:** _______________________________

Emergency Contact: ____**Phone Number:** _______________________________

Primary Health Insurance: _____________________________________ **ID#:** ____

Secondary Health Insurance: __________________________________ **ID#:**____

Auto Related: Y / N **Litigation: Y/N with Whom?** ____

Auto Insurance: ___________________________________**Claim #**___________________________**Date/Accident:**________________________

Adjustor Name: ___________________________________**Phone Number:**____

Attorney: Y/N with whom? ____

Work Comp Related: Y / N **Litigation: Y/N with whom?** ____

Insurance: ____**ID #**____

Adjustor Name: ____**Phone Number:** ____

PATIENT NAME: ____

PATIENT SIGNATURE: ____

REGIONAL REHAB ASSOCIATES, PA DBA

JAFFE SPORTS MEDICINE
PHYSICAL THERAPY | PAIN MANAGEMENT

FIRST NAME: ____________________ **LAST NAME:** ____________________ **DATE:** ____________

GENDER: ______________ **DOB:** ____________ **AGE:** ________ **RACE:** ____________________

OCCUPATION: ________________ **-REFERRED BY:** ______________ **Marital Status: M / S / D / W**

Chief Complaint : ____

DATE SYMPTOMS BEGAN: ________________ **Please Circle: Right or Left Handed**

HOW SEVERE IS YOUR PAIN? **<u>Current Pain Scale from</u> 0 – 10: 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10**

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:________________

IS THIS THE RESULT OF AN:

- ☐ AUTO ACCIDENT
- ☐ 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:

____

PLEASE LIST PAST SURGURIES:

________________________ ________________________
________________________ ________________________
________________________ ________________________

<u>History of Present Illness:</u>

Location of Pain **:** ____________________**Does your pain radiate into upper or lower extremeties? Yes / NO**

***Quality of Pain*: What does it feel like? Dull / Sharp / Aching / Throbbing / Pressure / Burning**

***Timing*:**

Onset - When does the pain start or is worse ? Morning / Afternoon / Nightime
Duration - How long have you had the symptoms? ____________________
Frequency – How often do the symptoms occure ? ____________________

***Setting*: Is your pain associated with: Home / Work / Personal Activiites / Emotional Reactions ?**

***Relieving or Exacerbating Factors*: What makes your pain better or worse ?** ________________________

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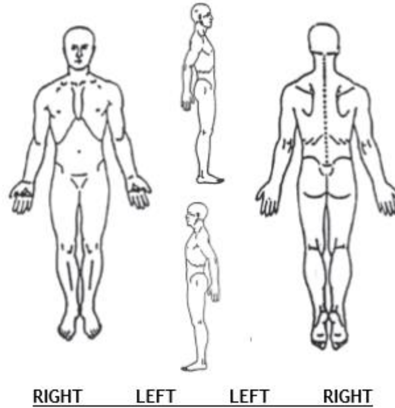
PLEASE INDICATE WHERE YOU ARE EXPERIENCING PAIN ON THE DIAGRAM.

VVVV = ACHING/DULL **////** = STABBING/SHARP **++++ = NUMBNESS**
OOOO = PINS & NEEDLES **XXXX** = BURNING



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 ____)
- ☐ OTHER: ____
- ☐ OTHER: ____

ANY CHANCE OF PREGNANCY? _____________________

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

☐ HEART DISEASE ☐ CANCER ☐ DIABETES ☐ LIVER DISEASE ☐ CHRONIC PAIN ☐ THYROID DISEASE ☐ ARTHRITIS ☐ KIDNEY DISEASE

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

☐ ALCOHOL CONSUMPTION YES OR NO (HOW MUCH) _________________ ☐ CIGARETTE SMOKING YES OR NO (PACKS / DAY) _____________
☐ RECREATIONAL DRUG USE YES OR NO

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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REVIEW OF SYSTEMS

For new patients, established patients who may be having a new problem, or our patients who we haven't seen for a while, we need to update our records as to your general medical health. In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, PLEASE CIRCLE THE ONES THAT APPLY, or explain any that may not be listed. If you have any questions about this, please ask one of the technicians, or your doctor.

Const. (Health in General) ❑ No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer. Other: ____ Ears,

Nose, Mouth & Throat ❑ No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness. Other: ____

C-V (Heart & Blood Vessels) ❑ No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other: _____________________________________

Resp. (Lungs & Breathing) ❑ No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray. Other:____

GI (Stomach & Intestines) ❑ No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other: ____

GU (Kidney & Bladder) ❑ No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Other: ____________________________________

MS (Muscles, Bones, Joints) ❑ No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other: ____

Integ. (Skin, Hair & Breast) ❑ No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: ___________________________

Neurologic (Brain & Nerves) ❑ No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other: ___________________________________

Psychiatric (Mood & Thinking) ❑ No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: ______________________

Endocrinologic (Glands) ❑ No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other: ______________________

Hematologic (Blood/Lymph) ❑ No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: _____________________________________

Allergic/Immunologic ❑ No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other: ____

REGIONAL REHAB ASSOCIATES, PA DBA

PO BOX 111090
NAPLES, FL 34108-0447
239-254-7778 FAX 855-959-1692

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:____________________ JAFFE

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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:____

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:** ________________