REGIONAL REHAB ASSOCIATES, PA DBA
PO BOX 111090
NAPLES, FL 34108-0447
239-254-7778 FAX 855-959-1692

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: ____

JAFFE SPORTS MEDICINE
PHYSICAL THERAPY | PAIN MANAGEMENT

REGIONAL REHAB ASSOCIATES, PA DBA
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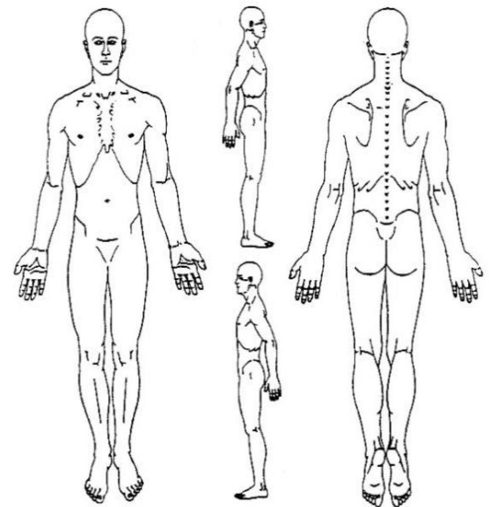
Patient Name: ____**Date:**_________________
Primary Care Physician: ___________________________________ **Occupation:**________________________________
Referring Physician / Source: ____

Assess Your Pain:
Where is your pain and where does it go? ____
When did it start? ____

Is it the result of: ☐ motor vehicle accident ☐ work-related injury ☐ other trauma

Intensity - on a scale of 1 – 10, with 1 being the lowest and 10 being the highest, please rate your pain below.
0 1 2 3 4 5 6 7 8 9 10

On the diagram at the right, please indicate where your pain is located.



Please describe your pain (check all that apply):
☐ SHARP ☐ DULL ☐ BURNING ☐ ACHING ☐ THROBBING ☐ CONSTANT
☐ INTERMITTENT ☐ OTHER: ___________________________________

Do you have any radiating pain, muscle weakness, pins and needle sensation, or loss of sensation? ☐ Yes ☐ No

Have you experienced bowel or bladder changes? ☐ Yes ☐ No

Does the pain affect your sleep? ☐ Yes ☐ No If yes, how?
____

Does pain affect your appetite? ☐ Yes ☐ No If yes, how?
____

How are you feeling emotionally? ☐ ANXIOUS ☐ DEPRESSED ☐ FRUSTRATED ☐ ANGRY ☐ OTHER _________________

List the activities that increase your pain : ____

List the activities that decrease your pain : ____

Diagnostic testing:
Please indicate whether you have had any of the following

MRI/CT	□ Yes	□ No	Where ______________________	When ______________________________
X-Ray	□ Yes	□ No	Where ______________________	When ______________________________
EMG/NCV	□ Yes	□ No	Where ______________________	When ______________________________
Phy. Therapy	□ Yes	□ No	Where ______________________	When ______________________________
Injections	□ Yes	□ No	Where ______________________	When ______________________________
Bone Scan	□ Yes	□ No	Where ______________________	When ______________________________
Other	□ Yes	□ No	Where ______________________	When ______________________________

Patient Initial: _______________

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Medical History:

Please list ***past pain medications*** that you have taken:

___________________ ___________________ ___________________ ___________________

Please list ***all current medications*** and ***dosage*** that you are currently taking:

___________________ ___________________ ___________________ ___________________

___________________ ___________________ ___________________ ___________________

Please list ***any allergies to medication*** or ***other allergies*** that you have:

___________________ ___________________ ___________________ ___________________

Pharmacy: ____ Phone Number: __________________

What treatments have you had for this pain problem? Please include dates and results

Treatment	**Pain Relief** Yes	No	**Type of Injections and When**
Nerve Block of Epidural Stero			
E-Stim / Tens Unit			
Physical Therapy			
Acupuncture			
Chiropractic			
Psychiatrist/Psychologist			
Medical Marijuana			
Other			

Please list your ***past*** and ***present*** medical problems:

___________________ ___________________ ___________________ ___________________ ___________________

___________________ ___________________ ___________________ ___________________ ___________________

Please check all the following health problems that you ***have now*** or ***have had in the past***:

☐ HEART DISEASE ☐ LUNG DISEASE ☐ LIVER DISEASE ☐ KIDNEY DISEASE ☐ GI DISORDERS ☐ DIABETES ☐ STROKE

☐ OTHER PAIN PROBLEMS ☐ CANCER (type/when):______________________________ ☐ OTHER: ______________________

Please list ***any surgeries*** that you have had, giving dates and procedure:

___________________ ___________________ ___________________ ___________________ ___________________

<u>Family / Social History:</u>

Please check ***any medical problems*** that run in your family:

☐ HEART DISEASE ☐ LUNG DISEASE ☐ LIVER DISEASE ☐ KIDNEY DISEASE ☐ GI DISORDERS ☐ DIABETES ☐ STROKE

Please describe your **present family situation**: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOW/ER

Do you drink **alcohol**? ☐ Yes ☐ No If yes, how often? ____

Do you **smoke**? ☐ Yes ☐ No If yes, how much/long? ____

Do you use **illegal substances**? ☐ Yes ☐ No If yes, what? ____

Are you **presently employed**? ☐ Yes ☐ No

Is there **any lawsuit or workman compensation** situation at present or pending? ☐Yes ☐ No

Patient Name: ____

Patient/Guardian Signature: ____ Date: ______________

Physician Signature:____ Date:_______________

JAFFE SPORTS MEDICINE
PHYSICAL THERAPY | PAIN MANAGEMENT

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Review Of Systems:

1. **Constitutional Symptoms**
   a. Fever ☐Yes ☐ No
   b. Chills ☐Yes ☐ No
   c. Headache ☐Yes ☐ No
   d. Other__________ ☐Yes ☐ No
2. Eyes
   a. Blurred Vision ☐Yes ☐ No
   b. Double Vision ☐Yes ☐ No
   c. Pain ☐Yes ☐ No
   d. Other__________ ☐Yes ☐ No
3. **Allergic Immunologic**
   a. Hay Fever ☐Yes ☐ No
   b. Drug Allergies ☐Yes ☐ No
   c. Other________ ☐Yes ☐ No
4. **Neurological**
   a. Tremors ☐Yes ☐ No
   b. Dizzy Spells ☐Yes ☐ No
   c. Numbness/Tingling ☐Yes ☐ No
   d. Other__________ ☐Yes ☐ No
5. **Endocrine**
   a. Excessive Thirst ☐Yes ☐ No
   b. Too hot/cold ☐Yes ☐ No
   c. Tired/Sluggish ☐Yes ☐ No
   d. Other__________ ☐Yes ☐ No
6. **Gastrointestinal**
   a. Abdominal pain ☐Yes ☐ No
   b. Nausea/Vomiting ☐Yes ☐ No
   c. Gerd/heartburn ☐Yes ☐ No
   d. Other__________ ☐Yes ☐ No
7. **Integumentary**
   a. Skin rash ☐Yes ☐ No
   b. Boils ☐Yes ☐ No
   c. Persistent Itch ☐Yes ☐ No
   d. Other__________ ☐Yes ☐ No
8. **Musculoskeletal**
   a. Joint Pain ☐Yes ☐ No
   b. Neck Pain ☐Yes ☐ No
   c. Back Pain ☐Yes ☐ No
   d. Other__________ ☐Yes ☐ No
9. **Ear/Nose/Throat/Mouth**
   a. Ear infection ☐Yes ☐ No
   b. Sore throat ☐Yes ☐ No
   c. Sinus problems ☐Yes ☐ No
   d. Other__________ ☐Yes ☐ No
10. **Genitourinary**
   a. Urine retention ☐Yes ☐ No
   b. Painful urination ☐Yes ☐ No
   c. Urinary frequency ☐Yes ☐ No
   d. Other__________ ☐Yes ☐ No
11. **Respiratory**
   a. Wheezing ☐Yes ☐ No
   b. Frequent Cough ☐Yes ☐ No
   c. Shortness of breath ☐Yes ☐ No
   d. Other__________ ☐Yes ☐ No
12. **Hematologic/Lymphatic**
   a. Swollen glands ☐Yes ☐ No
   b. Blood clotting prob. ☐Yes ☐ No
   c. Tired/Sluggish ☐Yes ☐ No
   d. Other__________ ☐Yes ☐ No
13. **Psychological**
   a. Depression ☐Yes ☐ No
   b. Suicidal thoughts ☐Yes ☐ No
   c. Dissatisfied w. life ☐Yes ☐ No
   d. Other__________ ☐Yes ☐ No

Note to patient: You are advised to follow up with your primary care physician for any general medical issues you have answered yes to.

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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:__________________

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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:** ______________