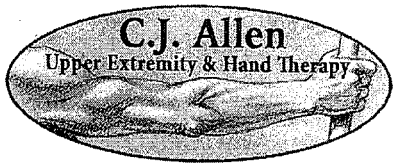


Rehabilitation & Custom Orthotics
2108 Joshua's Path (Route 111)
Hauppauge, NY 11788

Appt. Reminders: Please select one:

Email _____ **Voice Call ( )** _____ **Text Message ( )** _____

MED HISTORY

Name: _____ Date: _____

Have you ever had any of the following? ☑

Diabetes	Yes ☐ No ☐	Headaches	Yes ☐ No ☐
High Blood Pressure	Yes ☐ No ☐	Seizure	Yes ☐ No ☐
Heart Disease	Yes ☐ No ☐	Asthma	Yes ☐ No ☐
Heart Attack	Yes ☐ No ☐	Cancer	Yes ☐ No ☐
Pacemaker/ Defibrillator	Yes ☐ No ☐	Stroke	Yes ☐ No ☐
Kidney Problems	Yes ☐ No ☐	Nervous Disorders	Yes ☐ No ☐
Rheumatoid Arthritis	Yes ☐ No ☐	RSD/CRPS	Yes ☐ No ☐
Pregnant/Nursing	Yes ☐ No ☐	Circulation Disorders	Yes ☐ No ☐
Sensitivity to Heat/Ice	Yes ☐ No ☐	Previous Surgeries	Yes ☐ No ☐

When and how did your current injury occur?

_____

_____

Please include any other information about your medical history that you feel is pertinent:

_____

_____

Please list any medications you are currently taking along with approximate doses:

_____

_____

Please list any allergies:

_____

_____

Signature of Patient or Guardian

Patient Information

Name: _____ Referring Physician: _____

Address: _____ Injury/Diagnosis: _____

City: _____ State: ___ Zip: _____ Extremity Involved: _____ R _____ L _____

Phone: _____ Cell: _____ Date of Injury: _____ Work/Auto related: _____

Email: _____ Surgery Required: _____ Date: _____

Sex: _____ DOB: _____ SSN: _____ Splint Required: _____ Type: _____

Insurance Information

Insurance Company: _____ Name of Policy Holder: _____

Policy#: _____ Group/Claim#: _____ Relationship to Patient: _____

Phone: _____ Fax: _____ Policy Holder DOB: _____ SSN: _____

Claims Address: _____ Medicare Only:

_____ Enrolled in HHC/SNF: _____

Contact Person: _____ Where: _____ Phone: _____

For Office Use Only ↓
OT/PT/SP Visits per Calendar Year: _____ Workers Compensation Only- Employer Info:

Copay / Coins _____ : DME/Orthotic: _____ Employer: _____

Deductible: _____ Applied to Date: _____ Address: _____

PCP Referral/ Pre-Cert. Required: _____ Phone: _____

Secondary Insurance Information

Insurance Company: _____ Name of Policy Holder: _____
Policy#: _____ Group#: _____ Relationship to Patient: _____
Phone: _____ Policy Holder DOB: _____ SSN: _____

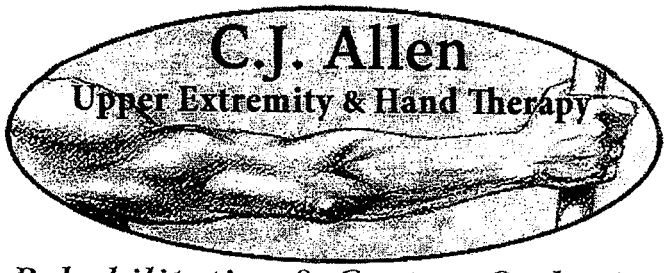
Responsible Party/ Emergency Contact Information

Name: _____ Phone: _____

Address: _____ Relationship: _____

I hereby certify that the information contained herein is accurate and complete to the best of my knowledge and that I am financially responsible for services rendered. I hereby authorize payment of insurance benefits to be made directly to C.J. Allen OT Upper Extremity & Hand Therapy, PLLC. for services rendered. I authorize any holder of medical information about me to release that information, as necessary to determine benefits or benefits payable for related services. I understand that the Explanation of Benefits provided by my insurance provider for services rendered supersedes any insurance coverage benefits explained herein, including, but not limited to copays, coinsurance, deductibles and authorized visits. In the event of default, I agree to pay all costs of services rendered.

Signature: _____ Date: _____



Rehabilitation & Custom Orthotics

C.J. Allen OT Upper Extremity & Hand Therapy, PLLC

2108 Joshuas Path (Rt. 111)
Hauppauge, NY 11788
Phone: 631-761-6996
Fax: 631-761-6997
Web: cjhandtherapy.com

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you may obtain access to this information.

C.J.Allen OT has always recognized the importance of privacy; this new federal law formalizes practices that have been followed routinely.

Background: In 1996, Congress recognized the need for national patient privacy standards and, as part of the Health Insurance Portability and Accountability Act, abbreviated as HIPAA, ordered that a set of rules be established to control how health information is used and disclosed, as maintained by doctors, hospitals, and health plans. Health information is considered sensitive and personal, and the law establishes consumer protection and limits the sharing of such information, as do similar protections already enacted for bank account, credit cards, and even video rentals.

- By law, consent is not required to discuss your medical treatment with your other doctors or health care providers. This allows, also, for a prescription to be called into your pharmacy and for scheduling of surgery in a hospital.
- Additionally, consent is not required in the course of carrying out health care operations, such as quality assessment, or in communication with your insurance carrier for payment related issues, or for incidental used, such as announcing a name in the waiting room or the use of sign-in sheets at the front desk. Also, we may release your medical information to a friend or family member if that person is involved in or is assisting in your care.
- Our practice will use and disclose your health information when we are required to do so by federal, state or local law. Our practice may disclose your health information to public health officials who are authorized by law to collect such information. Examples of such information are reports of child abuse or neglect, or reports of certain communicable diseases. Our practice will release your health information to law enforcement officials if we are required to do so by law.
- However, this office has always gone one step further in protecting you and does not believe in releasing specific information about you to any business or government entity without your written consent.
- Specific authorization is required to disclose protected information in non-routine circumstances, such as to your employer or for use in marketing a product to you.
- Medical information about you may be released for research and public health uses, as long as you are not individually identified.
- You are guaranteed access to review your medical records, and you may amend the record if you believe it to be incomplete or inaccurate. Such a request must be in writing to the Administrator and could be declined for certain specific reasons.
- You have the right to review when and to whom you information is released.
- You may suggest additional restrictions with regard to certain uses of disclosures, if you wish.
- Portions of this notice may be modified, as long as you are notified.
- Should you believe that your privacy rights have been compromised, you may report the violation, without penalty to you, to this office or to the Secretary of Health.
- The law requires that we make a good faith effort to obtain written acknowledgement of receipt of this notice for new patients, except in an emergency situation.

I, _____, have read and understand the contents of this document.

_____ _____ _____

Signature of Patient or Legal Guardian Name/Relationship to Patient Date

QuickDASH - Initial Patient name:_____ Date:_____

INSTRUCTIONS

This questionnaire asks about your symptoms as well as your ability to perform certain activities.
Please answer every question, based on your condition in the last week, by circling the appropriate number.
If you did not have the opportunity to perform an activity in the past week, please make your best estimate of which response would be the most accurate.
It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

1. Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand(e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups?	1	2	3	4	5
	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5
Please rate the severity of the following symptoms in the last week. (circle number)	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
	NONE	MILD	MODERATE	SEVERE DIFFICULTY	SO MUCH DIFFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? (circle number)	1	2	3	4	5

Therapist Use Only

Comorbidities:

- ☐Cancer
- ☐Diabetes
- ☐Heart Condition
- ☐High Blood Pressure
- ☐Multiple Treatment Areas
- ☐Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI)
- ☐Obesity
- ☐Surgery for this Problem
- ☐Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)

ICD Code: _____

MEDICARE PATIENTS

Name: _____ Date: _____

Enrolled in Home Health Care? Yes ☐ No ☐

If yes, where:

Phone: ( )

Height:	Weight:

Patient's Name: _____

Signature: _____

Date: _____