
*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: _____

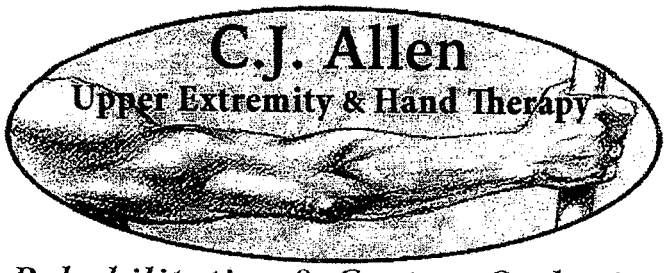
## Responsible Party/ Emergency Contact Information

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: _____

# NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW

## VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE

(This form is NOT for verification of hospital treatment)

| Name and Address of Insurer or Self-Insurer | Name, Address & Phone Number of Insurer's Claims Representative |
|---|---|
| | |

| Date | Policyholder | Policy No. | Date of Accident | Claim Number |
|---|---|---|---|---|
| | | | | |

Provider's Name and Address

C J Allen OT Upper Extremity & Hand Therapy, PLLC
2108 Joshua's Path Hauppauge, NY 11788

KINDLY COMPLETE AND SUBMIT THIS FORM AS SOON AS POSSIBLE. PLEASE NOTE, THIS COMPLETED FORM MUST BE SUBMITTED TO THE INSURER AS SOON AS REASONABLY POSSIBLE BUT NO LATER THAN 45 DAYS OR 180 DAYS AFTER THE TREATMENT DATE, DEPENDING UPON THE POLICY ENDORSEMENT IN EFFECT AT THE TIME OF THE ACCIDENT. IF YOU ARE UNSURE OF THE APPLICABLE TIME REQUIREMENT, KINDLY CONTACT THE CLAIMS REPRESENTATIVE TO DETERMINE WHICH DEADLINE IS APPLICABLE TO THIS CLAIM.

IF YOU HAVE PREVIOUSLY SUBMITTED AN EARLIER REPORT ON THIS ACCIDENT, YOU NEED ONLY NOTE ANY CHANGES FROM THE INFORMATION PREVIOUSLY FURNISHED AND ADDITIONAL CHARGES.

1. Patient's Name and Address

| 2. Date of Birth | 3. Sex | 4. Occupation (if known) |
|---|---|---|
| | | |

5. Diagnosis and Concurrent Conditions:

6. When did symptoms first appear?
Date:_____

7. When did patient first consult you for this condition? Date _____

8. Has patient ever had same or similar condition? ☐ Yes ☐ No IF "YES", state when and describe:

9. Is condition solely a result of this automobile accident? ☐ Yes ☐ No IF "NO", explain:

10. Is condition due to injury arising out of patient's employment? ☐ Yes ☐ No

11. Will injury result in significant disfigurement or permanent disability?
☐ Yes ☐ No ☐ Not determinable at this time
If "Yes", describe:

12. Patient was disabled (unable to work)
From _____ Through _____

13. If still disabled the patient should be able to return to work on : _____ (DATE)

14. Will the patient require rehabilitation and/or occupational therapy as a result of the injuries sustained in this accident? ☐ Yes ☐ No
If "Yes", describe your recommendation below:

CONTINUED ON PAGE 2

# VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE

(Page 2)

15. REPORT OF SERVICES RENDERED - ATTACH ADDITIONAL SHEETS IF NECESSARY

| Date of Service | Place of Service Including Zip Code | Description of Treatment or Health Service Rendered | Fee Schedule Treatment Code | Charges |
|---|---|---|---|---|
| | | | | |
| | | | TOTAL CHARGES TO DATE $ | |

16. If treating provider is different than billing provider complete the following:

| Treating Provider's Name | Title | License or Certification No. | Business Relationship Check Applicable Box | | |
|---|---|---|---|---|---|
| | | | Employee | Independent Contractor | Other (Specify) |
| | | | | | |

17. If the provider of service is a professional service corporation or doing business under an assumed name (DBA), list the owner and professional licensing credentials of all owners (Provide an additional attachment if necessary).

18. Is patient still under your care for this condition? ☐ Yes ☐ No

19. Estimated duration of future treatment

PATIENT: Your health provider may agree to accept payment for health services performed directly from your insurer (**Authorization to Pay Benefits**) so that you are not required to make payment to the health provider at the time of service. Such agreement is optional on the part of the health provider and must be signed by both patient and health provider. You may use the optional authorization language provided below, by checking off the designated spot in item 20 of this form.

20. ____ **(IF YOU HAVE CHOSEN TO AUTHORIZE THE DIRECT PAYMENT OF BENEFITS BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN ASSIGNMENT OF BENEFITS CONTAINED IN ITEM #21)**

**AUTHORIZATION TO PAY BENEFITS:**

**I AUTHORIZE PAYMENT OF HEALTH BENEFITS TO THE UNDERSIGNED HEALTH CARE PROVIDER OR SUPPLIER OF SERVICES DESCRIBED BELOW. I RETAIN ALL RIGHTS, PRIVILEGES AND REMEDIES TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT PROVISION) OF THE INSURANCE LAW.**

PRINT NAME_____ SIGNED_____

PATIENT PATIENT DATE

PATIENT: Your health provider may agree to have you assign you right to no-fault benefits from your insurer directly to your health provider (**Assignment of Benefits**). If you and your health provider agree to an assignment of benefits, you must both sign the agreement contained in #21 or the prescribed NF-AOB form or its equivalent. The language contained in the assignment of benefits is mandatory and may not be altered or avoided by any other language added to this agreement or other written agreement.

21. ✓ **(IF YOU HAVE CHOSEN TO ASSIGN YOUR BENEFITS TO THE HEALTH PROVIDER BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN AUTHORIZATION TO PAY BENEFITS CONTAINED IN ITEM #20 ABOVE)**

**ASSIGNMENT OF NO-FAULT BENEFITS:**

**I HEREBY ASSIGN TO THE HEALTH CARE PROVIDER INDICATED BELOW ALL RIGHTS, PRIVILEGES AND REMEDIES TO PAYMENT FOR HEALTH CARE SERVICES PROVIDED BY THE ASSIGNEE TO WHICH I AM ENTITLED UNDER ARTICLE 51(THE NO-FAULT STATUTE) OF THE INSURANCE LAW. THE ASSIGNEE HEREBY CERTIFIES THAT THEY HAVE NOT RECEIVED ANY PAYMENT FROM OR ON BEHALF OF THE ASSIGNOR AND SHALL NOT PURSUE PAYMENT DIRECTLY FROM THE ASSIGNOR FOR SERVICES PROVIDED BY SAID ASSIGNEE FOR INJURIES SUSTAINED DUE TO THE MOTOR VEHICLE ACCIDENT, NOTWITHSTANDING ANY OTHER AGREEMENT TO THE CONTRARY. THIS AGREEMENT MAY BE REVOKED BY THE ASSIGNEE WHEN BENEFITS ARE NOT PAYABLE BASED UPON THE ASSIGNOR'S LACK OF COVERAGE AND/OR VIOLATION OF A POLICY CONDITION DUE TO THE ACTIONS OR CONDUCT OF THE ASSIGNOR.**

PRINT NAME:_____ SIGNED:_____

PATIENT (ASSIGNOR) PATIENT DATE

PRINT NAME: Charles T. Allen SIGNED:_____

PROVIDER OF HEALTH CARE SERVICE (ASSIGNEE) PROVIDER OF HEALTH CARE SERVICE DATE

HAS AN ORIGINAL AUTHORIZATION OR ASSIGNMENT PREVIOUSLY BEEN EXECUTED? ☐ YES ☐ NO

IS THE ORIGINAL SIGNATURE OF THE PARTIES ON FILE? ☑ YES ☐ NO

**ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.**

| Date | Provider's Signature | IRS/TIN Identification No. | WCB Rating Code If None, Specialty |
|---|---|---|---|
| | | 47-2744496 | |