Narayan Rehabilitation Inc
Shriji Physical Therapy PC
Patient Information Sheet

Name:_____ SS#: _____
First MI Last

☐Male ☐ Female Date of Birth:____/____/____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address:_____ _____ _____
Street Address City State Zip Code Height Weight

E-mail Address:_____ Fax: (____) _____

Home Phone: (____) _____ ☐ Work or ☐ Cell Phone: (____) _____

DL#:_____ State Issued:_____ Please provide a copy for our records.

Employer:_____Occupation:_____

Emergency Contact:_____ Ph: (___) _____ Relationship: _____

Emergency Contact Address:_____
Street Address City State Zip Code

Physician Information

Referring Physician:_____ Date of Current Injury:_____

Office Address:_____ Ph: (____) _____
Street Address City State Zip Code

Appointment Policy

I understand that my doctor has prescribed therapy for me and that physical therapy is an on-going process which requires regular attendance to be optimally effective. I understand that if I am **15 minutes or more late** for an appointment, I may have to reschedule my appointment or may have to accept abbreviated treatment for that day. I understand that it is a policy of Narayan Rehabilitation Inc. to issue a $25 cancellation fee if given less than 24 hour notice. I understand that if I cancel or no-show for 3 appointments, Narayan Rehabilitation Inc. has the right to discharge me for being non-compliant.

Signature:_____ Date:_____
(Parent or Legal Guardian Must Sign if Under 18) Relationship To Patient: ☐ Mother ☐ Father ☐ Legal Guardian

Authorization For Treatment

I hereby consent to and authorize all therapy treatments, which in conjunction with the judgment of my attending physician, may be considered necessary and/or advisable for the diagnosis and/or treatment of the patient named above at Narayan Rehabilitation Inc.

Signature:_____ Date:_____
(Parent or Legal Guardian Must Sign if Under 18) Relationship To Patient: ☐ Mother ☐ Father ☐ Legal Guardian

How did you hear about us? Circle all that apply

Physician Family Friends Newspaper Radio Flier Health Fair Internet

Other:_____

Narayan Rehabilitation Inc.
Shriji Physical Therapy PC

Financial Policy And Insurance Information

I understand and agree that insurance claim forms will be submitted to my insurance company as a matter of convenience only, and that I am responsible for all charges regardless of my existing medical coverage. I understand that I am responsible for all supplies, such as braces, exercise equipment, and incontinence supplies, which I am provided during treatment, if they are not covered by my insurance plan. I understand that I will pay for supplies upon receipt and Narayan Rehabilitation Inc. will bill my insurance company and refund me any monies received by them from my insurance company for said supplies.

I hereby give authorization for payment of insurance benefits to be made directly to Narayan Rehabilitation Inc. for services rendered. In the event that my insurance company forwards payment directly to me, instead of Narayan Rehabilitation Inc., I will immediately deliver said payment to Narayan Rehabilitation Inc.

I understand and agree that I am wholly responsible and liable for payments of all charges assessed for professional services rendered and will pay any sum due upon demand. I understand and agree that if it becomes necessary to commence legal actions for the collection of any outstanding charges on my account, I will be responsible for any costs and/or court fees, in addition to the outstanding balance.

Signature of Person Responsible for Charges:_____ Date:_____
Relationship To Patient, if patient is under 18: □ Mother □ Father □ Legal Guardian

□Work Related □ Auto Related Case Manager Name:_____ Phone Number:_____

Primary Insurance Please provide a copy of all your insurances for our records.

Insurance Co._____ Ph: (____) _____

Subscriber #:_____ Group #/Name:_____

Name of Subscriber:_____ Date of Birth: _____/_____/_____

Relationship To Patient: □ Self □ Spouse □ Other _____

Address of Subscriber:_____
(If Different Than Patient) Street Address City State Zip Code

Ph: (____) _____ (____) _____ SS#:_____
(If Different Than Patient) Home Phone Cell Phone

Subscriber's Employer:_____ Ph: (____) _____

Secondary Insurance ***** If you have NO Secondary Coverage Initial Here (_____)**

Insurance Co._____ Ph: (____) _____

Subscriber #:_____ Group #/Name:_____

Name of Subscriber:_____ Date of Birth: _____/_____/_____

Relationship To Patient: □ Self □ Spouse □ Other _____

Address of Subscriber:_____
(If Different Than Patient) Street Address City State Zip Code

Ph: (____) _____ (____) _____ SS#:_____
(If Different Than Patient) Home Phone Cell Phone

Subscriber's Employer:_____ Ph: (____) _____

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Shriji Physical Therapy PC

The patient has the right to request information not to be sent to their health plan when paying for a health care item or health care service in full in cash, credit cards and checks too. Under the new Rule a patient can now come in and say they are going to pay you cash in full for the health care services they receive during this episode of care and they don't want you to send this information to their health plan. If they do in fact pay for the services in full, we cannot disclose information about the service they received to their health plan (or anyone else for that matter). If they fail to pay for the services in full in cash, then you can bill the health plan without violating the new Rule since you have a right to be paid for the services you provided.

The patient has the right to receive a copy of their health care record in a machine readable electronic format if the record is stored in an electronic format. If you cannot provide a copy of the electronic record in a machine readable format, then you must provide the patient a hard copy of their record.

The time period for complying with a patient's request for a copy of their record is now reduced from 60 days to 30 days with a one-time 30 day extension. You can no longer charge a "search and retrieval" fee for paper copies of the record.

Acknowledgement of Receipt of Notice of Privacy Practices

Narayan Rehabilitation Inc. reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices for Narayan Rehabilitation Inc.

Name of Patient:_____(Please Print)

Signature of Patient: _____(Parent of Legal Guardian Must Sign if Patient is under 18)

Relationship To Patient: □ Mother □ Father □ Legal Guardian Date:_____

Please Initial All That Apply

□_____Patient agrees to the release of medical or other information to process claim

□_____Patient agrees to accept assignment of payment

□_____Patient gives the office permission to leave a message on their answering machine or voice mail

□_____Patient gives permission to discuss their medical condition with another person, physician or emergency contact

Name:_____ Phone Number:_____ Relationship:_____
Name:_____ Phone Number:_____ Relationship:_____

Office Use Only (If Above Is Not Signed)

Documentation of Attempt to Obtain Acknowledgement of Receipt of Notice of Privacy Practice

Attempt to Obtain Acknowledgement

An attempt was made to obtain an acknowledgement of receipt of the Notice of Privacy Practices.
The acknowledgement was not obtained because:

□ The Patient declined to sign the acknowledgement □ Other_____

_____
Name of Patient (Please Print)

_____ Date_____
Name of Narayan Rehabilitation Inc. Employee

Narayan Rehabilitation Inc.
Shriji Physical Therapy PC

Patient's Name:_____ Date of Birth: ____/____/____

Medical History

Please check the appropriate answer.

	Yes	No		Yes	No		Yes	No
Allergies			Dizzy Spells			MRSA		
Anemia			Emphysema/Bronchitis			Multiple Sclerosis		
Anxiety			Fibromyalgia			Muscular Disease		
Arthritis			Fractures			Osteoporosis		
Asthma			Gallbladder Problems			Parkinson's		
Autoimmune Disorder			Headaches			Rheumatoid Arthritis		
Cancer			Hearing Impairment			Seizures		
Cardiac Conditions			Hepatitis			Smoking		
Cardiac Pacemaker			High/Low blood pressure			Speech Problems		
Chemical Dependency			High Cholesterol			Strokes		
Circulation Problems			HIV/AIDS			Thyroid Disease		
Currently Pregnant			Incontinence			Tuberculosis		
Depression			Kidney Problems			Vision Problems		
Diabetes			Metal Implants			Allergic to Latex		

Describe any other conditions and if "Yes" to any of the above, please explain and give approximate date

_____

_____

Fall History

Injury as a result of a fall in the past year? □ Yes □ No Date of Fall:_____

Two or more falls in the last year? □ Yes □ No Date of Falls:_____

Patient is at risk for falls? □ Yes □ No

Surgical History

Body Region:_____ Surgery Type:_____ Date of Surgery:_____

Body Region:_____ Surgery Type:_____ Date of Surgery:_____

Body Region:_____ Surgery Type:_____ Date of Surgery:_____

Current Medications

Drug:_____Dosage:_____Frequency:_____ Reason For Taking:_____

Drug:_____Dosage:_____Frequency:_____ Reason For Taking:_____

Drug:_____Dosage:_____Frequency:_____ Reason For Taking:_____

Drug:_____Dosage:_____Frequency:_____ Reason For Taking:_____

Drug:_____Dosage:_____Frequency:_____ Reason For Taking:_____

I, _____ deny taking any medications at this time_____.

Signature of Patient Date

Narayan Rehabilitation Inc.
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Patient's Name:_____ Date of Birth: ____/____/____

Patients Condition

Describe the problem for which you seek physical therapy: _____

_____

_____

When did the problem begin (onset date)? _____

What happened? _____

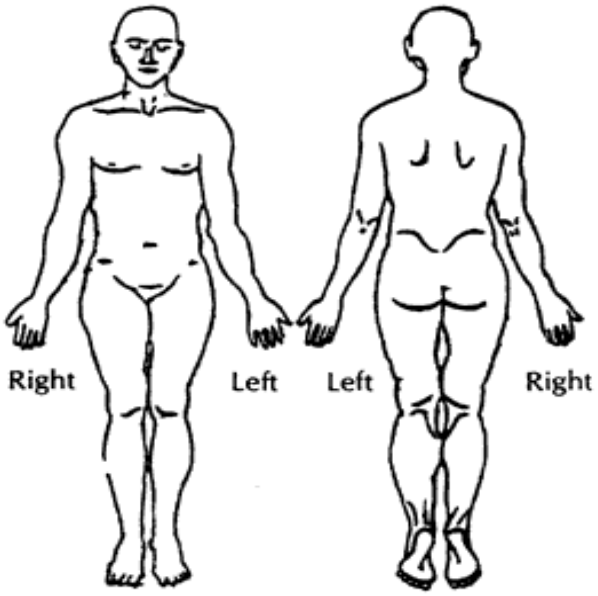
_____

_____

Have you had any tests? Circle all that apply: X-Ray's MRI's C.T. Scan's
Do you have any reports from tests done, as stated above? If so, Please provide a copy for our records.

On the body diagram to the right, please mark the location of your pain with X.

If you have any other symptoms, such as tingling or numbness, draw these as dotted lines.



Please describe your pain and intensity: circle all that apply!

Aching	Sharp
Annoying	Shooting
Burning	Spasms
Discomfort	Stiffness
Dull	Stinging
Nagging	Throbbing
Numbness	Tight
Pressure	Tingling

Pain Intensity Scale

0	1	2	3	4	5	6	7	8	9	10
No Pain	Slight		Mild	Moderate		Severe	Excruciating		Pain as bad as it can be	

Have you ever had this problem before? YES or NO What did you do for the problem?_____

Did the problem get better? YES or NO How long did the problem last? _____

How have you tried to resolve the problem?_____

What activities of daily living causes the problem to get worse?_____

_____

_____

Prior functional level:_____

Patient's goal for therapy:_____