475 Northern Boulevard
Suite 11
Great Neck, NY 11021
Tel: 516 829 0030
516 829 0410
Fax: 516 466 7723
information@reddycare.net
www.reddycare.net

Welcome to **Reddy-Care Physical Therapy.** We are delighted to have you as a client at our facility.

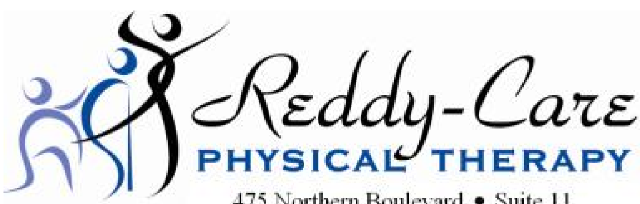
Reddy-Care Physical Therapy serves to provide quality physical therapy services in a close- knit, individualized therapeutic environment. We provide our services in an interactive environment, so all can share the results of our positive interactions.

We realize that our strength lies in our quality and team- oriented approach. Effective communications with physicians, family and patients has stood as a testament for our success. As you'll realize, we enjoy our roles as physical therapy providers and value the effort that it takes to service you.

Reddy-Care Physical Therapy stands firmly on its mission to fulfill the goals set by you the patient. Along with providing you the means of recovery, we strive to make your interaction with us wholesome and fun. As you'll come to notice, we take our jobs quite seriously and will only accept the best results. I welcome you to "go for the ride" and experience the results of good, quality physical therapy.

Sincerely,

Dr. Vinod Somareddy, PT
President & Clinical Director



Today's Date: ___________________________

PATIENT INFORMATION

Name____ ☐ Male ☐ Female
First MI Last

Address: ____
Street Address Apt. # City State Zip Code

Phone #'s: (_______) _______-__________ (_______) _________-_________ (_______) _______- ___________
Area Code Home Phone Area Code Work Phone Area Code Cell Phone

Date of Birth: ____/____/_____ Age: ____ Social Security #:______-_____-_________ DL (Please provide) (a copy for our files) ______________ ____
Month Day Year Number State

Employer: ____Occupation:____________________________

Address____
Street Address City State Zip Code

Email__________________________________ Married Single Divorced Widowed Date of Current Injury: _____________

Emergency Contact: ____ Home Phone: (______) ________- _________
First Last Area Code

Relationship to Patient: ______________________________________ Cell Phone: (______) ________- _________
Area Code

Person Responsible for Charges (If Patient is Under 18 Years of Age): _______________________Relationship to Patient:__________

Address (If Different from Above): ____
Street Address City State Zip Code

PHYSICIAN INFORMATION

Referring Physician: ____Office Phone: (______) ______- __________
First Last Area Code

Office Address:____
Street Address Suite # City State Zip Code

INSURANCE INFORMATION

Primary Insurance (Please provide card)

Name of Policy Holder: _______________________________ ____/_____/_____ _______-_____-_________
Date of Birth Social Security Number

Address of Policy Holder: ____
(If Different from Above) Street Address City State Zip Code

Insurance Co: ____ Phone #: (______) ________-__________
Area Code

Subscriber #:____________________________ Group #:_____________________________ ______________
Relationship to Patient

Policy Holder's Employer: ____
(If Different from Above) Name Address City State Zip Code

Secondary Insurance (If applicable, please provide card)

Name of Policy Holder: _______________________________ ____/_____/_____ _______-_____-_________
Date of Birth Social Security Number

Address of Policy Holder: ____
(If Different from Above) Street Address City State Zip Code

Insurance Co: ____ Phone #: (______) ________-__________
Area Code

Subscriber #:_____________________________________ Group #:_______________________ ______________
Relationship to Patient

Policy Holder's Employer: ____
(If Different from Above) Name Address City State Zip Code

Authorization for Treatment

I hereby consent to and authorize all therapy treatments, which in conjunction with the judgments of the attending physician may be considered necessary or advisable for the diagnosis or treatment of the patient named above, at Reddy-Care Physical Therapy.

Patient Signature: ____Relationship to Patient: ______________
(If Patient is Under 18 Years of Age, Parent or Legal Guardian must sign this authorization)

ALL INFORMATION ON THIS FORM IS CONFIDENTIAL

REVISED APR 2008

MEDICAL HISTORY

Have you ever suffered from any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Kidney Problems	☐	☐	Seizures	☐	☐
Cardiac Conditions	☐	☐	Liver Problems	☐	☐	Dizzy Spells	☐	☐
Heart Attack	☐	☐	Cancer	☐	☐	Diabetes	☐	☐
Pacemaker	☐	☐	Claustrophobia	☐	☐	Allergies	☐	☐
Circulation Problems	☐	☐	Vision Problems	☐	☐	Fractures	☐	☐
Arthritis	☐	☐	Speech Problems	☐	☐	Strokes	☐	☐
Osteoporosis	☐	☐	Sensitivity to Cold	☐	☐	Metal Implants	☐	☐
Nervous Disorders	☐	☐	Sensitivity to Heat	☐	☐	Are you pregnant?	☐	☐

Have you suffered from any illnesses not listed above? Yes ☐ No ☐ If yes, please explain:

____

____

Have you ever had surgery including this current condition? Yes ☐ No ☐
If yes, please list the type of surgery and the year it was done:

Type: ________________________ Date _______Type:_______________________ Date _______

Type: ________________________ Date_______ Type: _______________________ Date_______

Have you had therapy for your current condition? Yes ☐ No ☐ If yes, please list:

Location: __________________________ Dates: ________________________ # of Visits_______

Please list any medications, or herbal supplements you are currently taking:

Type: ____________________ Dosage: ______ Type: ___________________ Dosage: _______

Type: ____________________ Dosage: ______ Type: ___________________ Dosage: _______

Type: ____________________ Dosage: ______ Type: ___________________ Dosage: _______

What Body Part are we treating? ____

Are we treating you as a result of a fall? Yes ☐ No ☐

Have you fallen twice or more in the last year? Yes ☐ No ☐

Describe the history of your present condition. Please provide all important details.

____

____

____

What are your goals or expectations of therapy ____

____

Patient: ____ Date of Birth ______________

Signature: ______________________________________ Date: _____________________

APPOINTMENT POLICY

I understand that my doctor has prescribed therapy for me and that physical therapy is an ongoing process which requires regular attendance to be optimally effective. I understand that if I am late for my appointment, I may be given the opportunity to reschedule my appointment or to accept an abbreviated treatment for that day. I understand that if I cancel or no show for 3 consecutive appointments, Reddy-Care Physical Therapy has the right to discharge me from care for being non-compliant with my physician's orders.

I understand and agree that Reddy-Care Physical Therapy requires 24 hour advance notice of cancellation. If I fail to give 24 hour notice of cancellation or fail to show up for an appointment, I may be subject to a $15 charge (which is not covered by insurance).
If I fail to show up for an appointment without notice I will be charged $25 for the time that was held.

I have read and understand the appointment policy.

Signature: ______________________________________**Date:**_______________________
(Parent or Legal Guardian if patient is under 18)

INSURANCE and FINANCIAL POLICY

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 or exercise equipment, 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 Reddy-Care Physical Therapy will bill my insurance company and refund me any monies received by my insurance for the supplies.

I hereby give authorization for payment of insurance benefits to be made directly to Reddy-Care Physical Therapy for services rendered. In the event that my insurance company forwards payment directly to me, instead of Reddy-Care Physical Therapy, I will immediately deliver such payment to Reddy-Care Physical Therapy.

I understand and agree that I am totally responsible and liable for payment 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 action 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. I also give Reddy-Care Physical Therapy permission to appeal any services not covered by my insurance carrier, on my behalf.

Signature: ______________________________________**Date:**_______________________
(Parent or Legal Guardian if patient is under 18)

Patient ______________________________ Date of Birth _______________

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures
Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Reddy-Care Physical Therapy. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information
Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition.. We may also send you information describing other health-related products and services that we believe may interest you.

Fund-raising. Unless you request us not to, we will use your name and address to support our fund-raising efforts. If you do not want to participate in fund-raising efforts, please check off the following box.

[ ] **Please do not use my information for fund-raising purposes.**

Individual Rights
You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

Reddy-Care Physical Therapy. Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the facility office manager or the Director of Billing and Collections. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to
Patrick Flynn
VPA
475 Northern Blvd
Great Neck, NY 11021

Acknowledgement of Receipt of Notice of Privacy Practices

Reddy-Care Physical Therapy reserves the right to modify the privacy practices outlined in the notice.

Signature
I have received a copy of the Notice of Privacy Practices for **Reddy-Care Physical Therapy**.

____
Name of Patient (Print or Type)

____
Signature of Patient

____
Date

____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

____
Relationship of Patient Representative to Patient