REHABILITATION

Department of Orthopaedics & Rehabilitation

Occupational Therapy
Physical Therapy
Lymphedema Rehabilitation
Vestibular Rehabilitation

Dear Patient,

Welcome to the **Outpatient** Rehabilitation Division at New York Hospital Queens. Physical rehabilitation is a **joint and equal effort on the part of the patient, the therapist, and the physician**. This is an introductory letter to inform you of the basic policies and procedures adhered to by the Department of Orthopedics and Rehabilitation. If you have any questions, please direct them to your Therapist or Physician.

1. Prior to beginning therapy, you must meet with the administrative staff to pre-register and review your insurance information. If you have no insurance, you must submit your financial records to establish a payment plan with the cashiers department.

2. As determined by third-party insurers, **patients must be re-evaluated/re-certified monthly** by a physician for a continued need of outpatient physical and/or occupational therapy services.

3. It is **your responsibility to obtain an updated prescription every 30 days** to continue physical and/or occupational therapy. Please make sure you have a follow-up appointment scheduled with your physician when you begin physical and/or occupational therapy.

4. Physician fees are separate from therapy treatment fees.

5. Any equipment or supplies provided to you will be billed separately.

6. You will be given dates and times of your scheduled physical/occupational therapy appointments the day of your first visit. Please **arrive 15-minutes prior to your appointment** to prepare for your therapy session.

7. If you are unable to attend a scheduled appointment, it is your responsibility to contact the department **one-day prior for cancellation or to reschedule your appointment**.

8. **Patterns of lateness, missed visits, or cancellations will not be accommodated**. If the preceding occurs, **your program may be suspended.** In order to resume, you will need to be re-evaluated by your physician and be scheduled as a new patient.

9. Your goals of physical/occupational therapy will be discussed on your first visit. Your participation in establishing this plan of care together with your therapist is necessary for the best possible outcomes.

Please sign that you have read, understood, and will adhere to this introductory letter and orientation packet.

Patient Name (print) _____ Patient Signature _____

❑ Other (Please Explain)

OUTPATIENT REHABILITATION
Department of Orthopaedics & Rehabilitation
163-03 Horace Harding Expressway
Fresh Meadows, NY 11365
Tel: 1-855-37REHAB (73422)

Patient Name: _____

Patient Appt Date: _____

Medical Record: _____

DEMOGRAPHIC INFORMATION

❑ **Occupational Therapy** ❑ **Physical Therapy**

Today's Date: _____
Name of Therapist: _____
Diagnosis: _____ **ICD9:** _____

GENERAL INFORMATION

Address: _____ **Apt:** _____ **Floor:** _____

City: _____ **State:** _____ **Zip Code:** _____ **County:** _____

Home Number: (_____) _____- _____ **Sex:** ❑ Female ❑ Male **Race:** _____ **Date of Birth:** _____

Cell Number: (_____) _____- _____ **Religion:** _____ **Age:** _____

Social Security Number: _____ **Work:** ❑ Full-Time ❑ Part-Time ❑ Retired ❑ Disabled ❑ Unemployed

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Mode of Arrival: ❑ Walk ❑ Access-A-Ride ❑ Private Ambulance ❑ Police ❑ Public Transportation

Place of Accident: _____ **Onset Date (When did the problem first occur?):** _____

PHYSICIAN INFORMATION

Primary Physician: _____ **Office Number:** (_____) _____- _____

Referring Physician: _____ **Office Number:** (_____) _____- _____

EMPLOYER INFORMATION

Name of Employer: _____ **Date of Employment:** _____

Address: _____ **Office Number:** (_____) _____- _____

Occupation: _____ **Contact Person:** _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Person: _____ **Date of Birth:** _____ **Relationship:** _____

Address: _____ **City:** _____ **State:** _____**Zip Code:** _____

Home Number: (_____) _____- _____ **Cell Number:** (_____) _____- _____

Do you have a health care proxy or living will? ❑ Yes ❑ No

If under 18 years of age, please include:

Mother's Name: _____ **Father's Name:** _____ **Legal Guardian:** _____

INSURANCE INFORMATION

Medicare Number: _____ **Medicaid Number:** _____

Primary Insurance: _____ **Primary Insurance Number:** _____

Secondary Insurance: _____ **Secondary Insurance Number:** _____

Workers Compensation/No Fault Information: _____

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Patient Name: _____

Medical Record:_____

SELF ASSESSMENT INFORMATION

Medical History: ***(please check all that apply)***

❑ Asthma ❑ Cholesterol ❑ Cancer ❑ Cardiac ❑ Circulation ❑ High Blood Pressure ❑ Low Blood Pressure ❑Respiratory ❑ Pregnant ❑ Osteoporosis
❑ Renal/Kidney ❑ Stroke ❑ Smoking ❑ Cardiac Surgery ❑ Pacemaker ❑ Hand Surgery ❑ Shoulder Surgery ❑ Hip Surgery ❑ Knee Surgery
❑ Ankle/Foot Surgery ❑ Hepatitis ❑ HIV ❑ Other_____

Social History: ***(please check all that apply)***

I live ❑ alone ❑ with family ❑ with children ❑ other: _____

I live in a/an ❑ house ❑ apartment

I have ❑ No steps to enter ❑ steps to enter. How many steps? _____

I have a Home Health Aide ❑ Yes ❑ No

If yes, my Home Health Aid helps me with:

❑ dressing ❑ bathing ❑ eating ❑ walking ❑ cleaning ❑ cooking ❑ outdoor activities

I am ❑ not working ❑ working as a _____ *(your position)*

Therapy History: ***(please check all that apply)***

❑ I never had therapy.

❑ I had therapy for my ❑ hands ❑ arms ❑ neck ❑ shoulders ❑ back ❑ hips ❑ knees ❑ feet ❑ _____

When did you have therapy? ❑ _____weeks ago ❑ _____months ago ❑ _____years ago

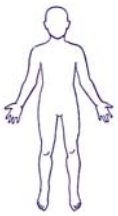
Patient Goals: *(please explain)* _____

Level of Function: ***(please check appropriate response)***

	CURRENTLY		PRIOR TO INJURY	
I am able to:	**Independent**	**Requires Assist**	**Independent**	**Requires Assist**
hold utensil for feeding				
put on shirt				
put on pants, socks, and shoes				
toileting				
get in and out of bed				
walk		❑ with a walker ❑ with a cane ❑ with hand held assist ❑ use a wheelchair		❑ with a walker ❑ with a cane ❑ with hand held assist ❑ use a wheelchair
use stairs				
stand				

Level of Pain: Pain Scale: *(please circle appropriate response)* 0 1 2 3 4 5 6 7 8 9 10

No Pain — Moderate Pain — Worst



Please circle where you have pain.

My pain is ❑aching ❑radiating ❑dull ❑sharp

My pain occurs in the ❑morning ❑night ❑ when I wake up ❑ as the day progresses

I have pain when I ❑sleep ❑perform certain activities *(please list)*_____

RECEIPT OF:
HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

Effective Date: 4/14/03

This notice describes how protected health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

New York Hospital Queens is required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice which describes the health information privacy practices of our hospital, its medical staff, and affiliated health care providers that jointly perform payment activities and business operations with our hospital. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Signature _____**Date** _____

Patient / Health Care Agent/ Guardian / Relative Signature

(This signature indicates that you have received a copy of the Notice of Privacy Practices.)

❑ Patient is unable to sign due to medical reasons

❑ Patient refuses to sign

❑ Other (Please Explain) _____

This Acknowledgement Form will become a part of your permanent medical record.

9200-330 HIPAA Notice of Privacy Practices Policy