WESTVIEW HEALTH CARE CENTER

PATIENT INFORMATION

WESTVIEW
Outpatient Therapy
& Aquatic Center

REFERRING PHYSICIAN: _____
First Name Last Name

Phone Number: _____

PRIMARY PHYSICIAN: _____
First Name Last Name

Phone Number: _____ _____

PATIENT INFORMATION (Please Print)

NAME (First Name, Last Name, Middle Name)	SOCIAL SECURITY #	DATE OF BIRTH		☐ MALE ☐ FEMALE
MAILING ADDRESS E – MAIL :	CITY	STATE	ZIP CODE	HOME PHONE
EMPLOYER/SCHOOL	OCCUPATION			WORK PHONE
EMPLOYER ADDRESS	CITY	STATE	ZIP CODE	MARITAL STATUS ☐ Sing. ☐ Marr. ☐ Other
HAVE YOU RECEIVED THERAPY SERVICES ANYWHERE ELSE THIS CALENDAR YEAR? ☐ YES ☐ NO How many visits?_____	HOW DID YOU HEAR ABOUT US? ☐ Friend/Relative ☐ Physician ☐ Commercial ☐ Newspaper ☐ Billboard ☐ Internet ☐ Other_____			
IS CONDITION AUTO RELATED? ☐ YES ☐ NO	IS CONDITION WORK RELATED? ☐ YES ☐ NO	OTHER ACCIDENT? (Please explain) ☐ YES ☐ NO		
PARENT OR GUARDIAN'S NAME	NEXT OF KIN	PHONE NO.		

EMERGENCY CONTACT

NAME	RELATIONSHIP	PHONE NO.

PRIMARY INSURANCE

PRIMARY INSURANCE COMPANY NAME	MEMBER ID #			GROUP #
SUBSCRIBER'S NAME	SOCIAL SECURITY #	DATE OF BIRTH		☐ MALE ☐ FEMALE
MAILING ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE
EMPLOYER	OCCUPATION			WORK PHONE

SECONDARY INSURANCE

SECONDARY INSURANCE COMPANY NAME	MEMBER ID #		GROUP #
SUBSCRIBER'S NAME	SOCIAL SECURITY #	DATE OF BIRTH	☐ MALE ☐ FEMALE

I hereby authorize WESTVIEW HEALTH CARE CENTER to leave answering machine/voicemail messages or give messages regarding my visit (Name of Person) _____ either at home or work.

PATIENT SIGNATURE X	DATE

MEDICARE SIGNATURE

NAME OF BENEFICIARY	ID #

I request that payment of the authorized Medicare benefits be made either to me on my behalf or to WESTVIEW HEALTH CARE CENTER for any services furnished me by that physician. I authorize any holder of medical information about me to release the Health Care Financing Administration and its agents any information needed to determine those benefits payable to related services.

I understand my signature requests that payment be made and authorizes release if medical information necessary to pay the claim. If item 12 of the HCFA 1500 claim form is completed, my signature authorizes releasing of the information to the insurer of agency shown. In Medicare assigned cases, though physician of supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

SIGNATURE OF BENEFICIARY X	DATE

ASSIGNMENT OF BENEFITS

I, _____ hereby assign medical and/or surgical benefits to include major medical benefits to which I am entitled to: WESTVIEW HEALTH CARE CENTER. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize as said assignee to release all information necessary to secure payment of said benefits.

SIGNATURE X	DATE	WITNESS

150 Ware Road, Dayville, CT 06241 • Tel 860-412-7660 • Fax 860-412-7661

WESTVIEW
Outpatient Therapy
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WESTVIEW HEALTH CARE CENTER

PATIENT HISTORY & OUTPATIENT ADMISSION FORM

NAME (First Name, Last Name, Middle Name)	DATE OF BIRTH	TODAY'S DATE:

Your home town? _____

What is your current problem? _____

_____

When did it begin? _____ Who has treated you for this? _____

What Pharmacy did you use? _____

PHONE: _____ TOWN: _____

CURRENT MEDICATIONS

DRUG	DOSE	Rx - MD	TAKEN FOR:	DATE Rx

MEDICATION ALLERGIES ☐ **No Known Allergies**

DRUG	REACTION	DATE OF REACTION

SENSITIVITIES TO PAIN MEDICATIONS:

DRUG	YES	NO	REACTION
Vicodin			
Anti-Inflammatory			
Other			
Sensitivity to Latex			

YOUR OTHER DOCTORS (including Primary Doctor)

NAME	SPECIALTY	PHONE #	FAX #	ADDRESS

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SOCIAL HISTORY – ☒ Check all that Apply						
Alcohol	☐ Denies	☐ Heavy	☐ Moderate	☐ Occasionally	☐ Never	
Drug Use:	☐ Past	☐ Present	☐ Never	What:		
Employment:	☐ Full time	☐ Part time	☐ Retired	☐ Disabled	☐ Student	☐ Unemployed
Tobacco:	☐ Non Smoker ☐ Quit: _____	☐ Cigarettes (☐<1 PPD, ☐1-3 PPD, ☐>3 PPD)			☐ Cigar	☐ Chew

YOUR ILLNESSES & HOSPITALIZATIONS – ☒ Check all that Apply			
☐ Alcoholism	☐ Depression	☐ Hepatitis Type ___	☐ Polio
☐ Alzheimer's Disease	☐ Diabetes – Insulin	☐ Hiatal Hernia	☐ Polymyalgia Rheumatic
☐ Anemia	☐ Diabetes - Medications	☐ Hyperlipidemia (High Cholesterol)	☐ Prostrate Hypertrophy
☐ Aneurysm	☐ Diabetes - Diet	☐ Hypertension (High Blood Pressure)	☐ Pulmonary Disease
☐ Arthritis	☐ Diverticulitis	☐ Hepatitus Type ____	☐ Renal Disease
☐ Rheumatoid Osteoarthritis	☐ Eyes- Glaucoma	☐ Hiatal Hernia	☐ Dialysis
☐ Asthma	☐ Eyes – Macular Degeneration	☐ Irritable Bowel Syndrome	☐ Rheumatic Fever
☐ Bleeding Disorder	☐ Fibromyalgia	☐ Liver Disease	☐ Seizure Disorder
☐ Cancer /Where _____	☐ Gastric Ulcer	☐ Migrane Headaches	☐ Skin Disease
☐ Chemotherapy	☐ GI Bleed	☐ Sleep Apnea	☐ Syncope
☐ Cerebral Palsy	☐ Gout	☐ Osteoporosis	☐ Thromboembolism
☐ CVA/Stroke	☐ Heart Disease	☐ Pancreatic Disorder	☐ Thrombophlebitis
☐ Cholelithiasis	☐ Angina	☐ Parkinson Disease	☐ Thyroid Disease
☐ COPD/ (Chronic Pulmonay Disease)	☐ Arrhythmia	☐ Peripheral Vascular Disease	☐ Hyperthyroidism
	☐ Heart Murmur	☐ Pneumonia	☐ TIA / Stroke
	☐ Heart Valve Disease		☐ Tuberculosis
	☐ Mitral Valve		☐ Varicose Veins
	☐ Prolapsed		
	☐ Myocardial Infraction (Heart Attack)		

FAMILY HISTORY – ☒ Check all that Apply			
☐ Alzheimer	☐ Cancer	☐ Gout	☐ Psychiatric Disorder
☐ Aneurysm	☐ Circulatory Problems	☐ Heart Disease	☐ Seizure Disorder
☐ Arthritis	☐ Diabetes	☐ High Cholesterol	☐ Stroke
☐ Bleeding Disorder	☐ Genetic/ Hereditary	☐ Hypertension	☐ Tuberculosis
☐ Blood Clots	☐ Disorder	☐ Leukemia	☐ Kidney Disease
☐ Breast Cancer	☐ GI Disease or Ulcer	☐ Obesity	

OTHER ORTHOPEDIC PROBLEMS	R/L OR BOTH	DATE OF ONSET

PAST ORTHOPEDIC OPERATIONS	R/L OR BOTH	DATE OF SURGERY

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Signature:_____ **Date:**_____
Patient, Parent/Guardian, or Authorized Representative of Patient

WESTVIEW OUTPATIENT THERAPY & AQUATIC CENTER
150 Ware Road ♦ Dayville, CT 06241
Phone: (860) 412-7660 ♦ Fax: (860) 412-7661
Website: www.westviewhcc.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

NOTE TO PATIENT:
A signed authorization form is required by some healthcare providers & attorneys to have permission by the patient to legally release any requested documentation to our clinic; i.e., Radiology Reports, MRI Reports, Operative Reports, & other related documentation.

Patient Name: _____ **Date of Birth:** _____
First Last

Maiden Name: _____ Social Security: _____
(If Applicable)

I herein authorize **Westview Outpatient Therapy & Aquatic Center** the right to obtain and receive the following information:

(Please check the following documents / reports authorized to be obtained)

- ☐ X-Ray Images / Radiology Reports / MRI Reports
- ☐ Surgical / Operative Reports (recommended to be authorized if you are a post-operative patient)
- ☐ Office Visit Chart Documentations
- ☐ Treatment & Discharge Summaries from previous physical therapy clinic(s) (if applicable) and or hospital / emergency room visits
- ☐ Other: _____

Signature:_____ **Date:**_____
Patient, Parent/Guardian, or Authorized Representative of Patient

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INSURANCE INFORMATION / Instructions for Completion:

Please check all that apply for questions 1 through 3 and sign and date at the bottom of this page (even if you've checked "No" for all questions we still require a signature for confirmation.) Thank you.

Patient Name:

1) IS THIS A WORKER'S COMPENSATION CLAIM? ☐ **YES** ☐ **NO**

Date of Injury: _____

Company Name: _____

Address: _____
Street City State Zip

Phone #: _____ **Claim #:** _____

Adjuster Name: _____

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2) IS THIS AN ACCIDENT CASE? VEHICLE: ☐ **YES** ☐ **NO** OTHER: ☐ **NO** ☐ **YES**:_____

Date of Injury: _____

Insurance Company to Bill: _____

Address: _____
Street City State Zip

Phone #: _____ **Claim #:** _____

Adjuster Name: _____

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3) IS THERE AN ATTORNEY INVOLVED IN YOUR CASE? ☐ **YES** ☐ **NO**

Attorney's Name: _____ Phone: _____

Address: _____
Street City State Zip

I hereby authorize **Westview Outpatient Therapy & Aquatic Center** to furnish information to the insurance carriers concerning my treatment and hereby assign to the therapist(s) all payment for services rendered. I understand that I am responsible for all charges, even those not paid by my insurance. I understand that by signing I am giving my permission for treatment. I also authorize **Westview Outpatient Therapy & Aquatic Center** to contact the insurance commissioner on my behalf, to assist me in receiving my full insurance benefits, if deemed necessary.

Signature:_____ **Date:**_____
Patient, Parent/Guardian, or Authorized Representative of Patient

Name: _____ **Date:** _____
Patient

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CANCELLATION POLICY

Exceptional care is our goal and we strive to make it possible for all patients to maintain appointments and achieve an optimal level of health. Because our patients truly value their physical therapy program, we ask that you please honor our **attendance policy. Please sign below to confirm you've acknowledged & accept all aspects of this policy.**

PLEASE **READ & INITIAL** THE FOLLOWING:

1) Westview Outpatient Therapy and Aquatic Center requires **24 hours notice** prior to the cancellation or reschedule of any appointment. (Excluding: emergencies, serious illness, & severe weather conditions.) If you cancel without 24 hours notice you will be charged $25 that must be paid on your next visit.

Initial: _____

2) If you are more than **15 minutes late** for your scheduled appointment, we reserve the right to cancel the appointment or decrease treatment time per the therapist's discretion.

Initial: _____

3) Westview Outpatient Therapy and Aquatic Center has scheduled appointments. If you fail to provide notice of cancellation, a no-show fee shall be charged. We understand oversights do occur, which is why there is no penalty for the first no-show; however, there is a **$25 charge for every no-show after**. The $25 must be collected on your next visit. Please understand that your scheduled visit(s) precludes other patients from access to services in your time slot.

Initial: _____

Patient Name (Print): _____

Signature: _____ Date: _____
Patient, Parent/Guardian, or Authorized Representative of Patient

WESTVIEW HEALTH CARE CENTER

Acknowledgment of Receipt of Privacy Notice

Documentation of Attempt to Obtain Written Acknowledgment

As required by the Health Insurance Portability and Accountability Act of 1995, we document compliance by retaining copies of our privacy notices and any written acknowledgments of receipt of the privacy notice or documentation of good faith efforts to obtain such written acknowledgment in accordance with our obligation to provide the privacy notice at first service after compliance date, or, when an emergency occurs, as soon as possible after emergency treatment.

_____ I have received the Privacy Notice

Signed: _____ Date: _____

If not signed by patient, please indicate your relationship to the patient: _____

____ We have made a good faith effort to deliver a copy of our Privacy Notice to:

Patient Name: _____

Signed: _____ Date: _____
(Privacy contact person)

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WESTVIEW HEALTH CARE CENTER

A NOTICE ABOUT OUR PRIVACY POLICY

We are providing you with this notice of our Privacy Policy in accordance with the Federal Health Insurance Portability and Accountability (HIPPA) Act of 1996. This Act regulates how we use and disclose your protected health information. Your protected health information, or PHI, is personal information that concerns your past, present or future physical and mental health condition. This notice explains your right to access and control your PHI.

Your Rights:

- You have the right to request restrictions on certain uses and disclosures of your PHI
- You have the right to choose how and where we contact you
- You have the right to inspect or copy your medical records
- You have the right to request amendments to your records
- You have the right to receive an accounting of some disclosures of your PHI

All requests must be in writing. We will provide you with the appropriate request form. We are required to agree to your requests.

Uses and Disclosures for Treatment, Payment or Operations:

Treatment: We will use and disclose your PHI to provide, coordinate, and manage your health care. For example, if you were referred by another physician for treatment, we will provide that physician with part or all of your medical records.

Payment: We will use your PHI to obtain payment for our services. For example, we may submit claims on your behalf to your insurance company, or disclose selected PHI to a company which performs billing or collections services for us.

Operations: We may use your PHI to carry out other operations of our medical practice. Our practice may share minimal PHI with business Associates, which perform services for us. Our business associates are pledged to safeguard your privacy.

Reminders or Treatment Options: We may contact you and remind you of your next appointment. We may provide information to you about treatment alternatives or other services that may be of interest.

Uses and Disclosures without your authorization: We may use and disclose your PHI for public health purposes, for health oversight activities, to report abuse or neglect, for Workers' Compensation programs, or for national security and intelligence.

Our Duties:

We are required by law to maintain the privacy of your PHI and to provide you with this notice of our legal duties and privacy practices with respect to PHI. We will follow the terms of the notice currently in effect. We reserve the right to change the terms of our privacy notice at any time, and make any revised notice provisions effective for all PHI that we created or received prior to issuing the revised notice. We will not implement any change prior to its effective date. Any revised notice will be posted in the lobby and be available from our Privacy Officer.

Privacy Complaints:

You may complain to out Privacy Officer if you believe your privacy rights have been violated. You may also complain to the Secretary of Health and Human Services. You will not be retaliated against for filing a complaint.