GAIT+BALANCE/VESTIBULAR MEDICAL HISTORY

Name: _____ Age: _____ DOB: _____ Height_____ Weight_____

Describe your current complaint: _____

_____

When did your condition begin? Date/Year _____ How did your problem begin? _____

_____

Have you been treated for this same problem in the past? Yes or No
If yes, please describe: _____

Have you recently had surgery pertaining to your current condition? Yes or No
If yes, please describe: _____

Have you fallen in the last year? Yes or No

Since your condition began, have your symptoms: decreased not changed increased
What makes your problem better? _____
What makes your problem worse? _____
Are your symptoms constant or intermittent? _____

Please circle **Yes or No** to the following:
Do you experience:

Difficulty hearing?	Yes	No	If yes, please circle which ear? L R Both
Change in hearing with dizziness?	Yes	No	
Noise in your ears?	Yes	No	If yes, please circle which ear? L R Both How often? _____
Fullness or stuffiness in your ears?	Yes	No	If yes, please circle which ear? L R Both
Pain in your ears?	Yes	No	
Discharge in your ears?	Yes	No	
Sensitivity to light, sound or smell?	Yes	No	
Blurred vision?	Yes	No	
Double vision?	Yes	No	
Blindness?	Yes	No	
Weakness in your face?	Yes	No	
Numbness in face/extremities/lips?	Yes	No	
Weakness in arms or legs?	Yes	No	
Confusion or loss of consciousness?	Yes	No	
Difficulty with Speech?	Yes	No	
Difficulty swallowing?	Yes	No	
Migraines/Headaches?	Yes	No	

If yes to migraines/headaches, how often? _____ Have you received treatment? Yes No

Difficulty with memory/concentration?	Yes	No	
Were you ever in a motor vehicle accident?	Yes	No	If yes, when? _____
History of head injury or concussion as adult or child?	Yes	No	If yes, when? _____
Spinal problems such as Stenosis, Herniated disc?	Yes	No	
Numbness/Tingling in feet?	Yes	No	

PT INITIALS _____

History of earaches or ear infections as a child? Yes No
Motion sickness before age 12? Yes No
Motion sickness in the last 10 years? Yes No

History of cataract, glaucoma, macular degeneration, or other vision problems? Yes No
Recent head cold or virus? Yes No
Sinus, ear, or upper respiratory infection? Yes No
Recent illness resulting in bedrest? Yes No

Please check any of the following that are in your health history:

___ Asthma
___ Shortness of Breath
___ Coronary Artery Disease
___ Pacemaker
___ Chest Pain
___ Heart Surgery
___ Heart Attack
___ Cardiac/Arrythmia
___ Stroke or TIA
___ Blood clot or emboli
___ Check if Pregnant
___ Sleeping Problems
___ Anemia
___ Neurological Problems
___ Diabetes
___ High Blood Pressure
___ Cancer
___ Osteoporosis
___ Thyroid trouble or Goiter
___ Weakness
___ Smoking
___ Allergies
___ Infectious Disease
___ Autoimmune disease
___ Weight Loss
___ Epilepsy or Seizure
___ Kidney disease/dialysis
___ Arthritis/swollen joints
___ Fainting
___ Hyperventilation
___ Incontinence

Please check if you have experienced any of the following:
___ Panic attacks ___ Anxiety ___ Depression ___ Night sweats ____ Phobias
Are you receiving counseling for any of the above conditions? Yes No
Recent period of stress? Yes No Death of loved one? Yes No

Social Living Environment:
Do you live? ____ Alone ____ With Spouse ____ With Family Other: _____
Do you live in a: ____ House ____ Apartment ____ Assisted Living

Please check any of the following services that you have received for this condition:

____ Orthopedist ____ Physical Therapy ____ X-Rays ____ EMG
____ Chiropractor ____ Occupational Therapy ____ CT Scan ____ NCV
____ Neurologist ____ Massage Therapy ____ MRI ____ VNG
____ General Practitioner ____ Emergency Room ____ Myelogram other: _____

Please list any medications you are currently taking: _____

_____

_____

Please list any past surgeries: _____

_____

_____

Please list any past hospitalizations: _____

_____

_____

Patient/Guardian Signature: _____ Date: _____

I have read and reviewed the medical history of _____.

_____ _____
Physical Therapist Signature Date

PEAK PERFORMANCE

an Ivy Rehab Physical Therapy Partner

Missed Appointment Policy:

Peak Performance at Ivy Rehab Physical Therapy is committed to providing our patients with exceptional care. Your Doctor and therapist will determine a prescribed treatment frequency to maximize your healing. To ensure we get you back to doing the things you love, please note some important facts about canceling and rescheduling your appointments.

- We require a phone cancellation 24-hours prior to your scheduled appointment. To ensure you remain on your prescribed therapy course, please have an alternative time in mind to reschedule this appointment.
- When rescheduling your appointment, your availability may require you to see another therapist. All of our therapists are experienced professionals, and be assured that your primary therapist will review your specific case with them prior.
- For all appointments missed or canceled with less than 24-hour's notice, a **$25 fee will be administered.**

Our mission is getting you to meet your recovery goals, and we look forward to working with you.

_____ _____

Signature of patient or patient's representative Date

If this form is signed by the patient's representative, please provide your complete name below.

_____

Name of patient's representative

Acknowledgment of Receipt of Notice of Privacy Practices

I, _____ have received a copy of this office's Notice of Privacy Practices.

Patient

Patient Signature: _____

Signature: _____ Date: _____

If not the patient

Print Legal Guardian Name: _____

Signature: _____ Date: _____

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, however, acknowledgment could not be obtained because:

Please check applicable box

☐ Individual refused to sign

☐ Communication barriers prevent us from obtaining an acknowledgment

☐ An emergency situation prevent us from obtaining acknowledgment

☐ Other, please specify, _____

ivyrehab
PHYSICAL THERAPY

CONSENT FOR TREATMENT

1. **AUTHORIZATION:**
   a. I hereby authorize Ivy Rehab's health care professionals and students to provide such medical care and to administer such treatment, necessary to the named patient or me each time I or the named patient present to an ambulatory care service. Such procedures and treatments may include, Physical Therapy, Occupational Therapy & Speech Therapy. To the extent possible I have been informed of risks and complications that may occur and alternatives that may be available.

   b. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from my treatment.

2. **MEDICARE PATIENTS:**
   a. I authorize any holder of medical or other information about me to be released to the Social Security Administration, its intermediaries, carriers and information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

3. **GUARANTEE OF ACCOUNT:**
   a. For and in consideration of services rendered to (Patient Name) by Ivy Rehab. I hereby agree to pay the full bill for all charges which are not paid to Ivy Rehab by insurance carriers, Worker's Compensation, No-fault or any balance due which is not covered by insurance or excluded by a co-insurance clause.

4. **RELEASE OF INFORMATION:**
   a. I permit Ivy Rehab to disclose all or part of the above patient's medical records to any person, corporation, or agency when required for the collection of benefits or payment of Ivy Rehab charges.

5. **HIPAA – NOTICE OF PRIVACY ACKNOWLEDGMENT :**
   a. Ivy Rehab has made their Notice of Privacy Practices available to you. Your name, signature, time and date on this cover sheet indicate that you have acknowledged the availability of the Ivy Rehab's Privacy Practices and were given the option to receive a copy for your possession. If you have any questions regarding the information set forth in the Ivy Rehab's Notice of Privacy Practices, please do not hesitate to contact the Ivy Rehab's Privacy Officer: Grace Jenson Tele: 914/777-8700 or Fax Inquiries to: 914/777-8705

I confirm that I have read and fully understand the above.

Facility Name:

Patient Name: **Patient Signature:** _____

Relative/Guardian (if not patient): _____ _____
(Signature) (Print name)

Relationship (if signed by person other than patient) _____

(If Required) Interpreter: _____ _____
(Signature) (Print name)

Rep Name (Witness): _____ _____ _____
(Signature) (Print name) (Date)

To all of our valued patients at ,

IVYREHAB Network, Inc will be submitting your rendered services to the insurance carrier information you provided to us. As a result, you will be receiving an "Explanation of Benefits" (EOB) statement from your insurance company. An "Explanation of Benefits" is not a bill from **IVY REHAB** it is a statement from your insurance carrier informing you of the charges submitted on your behalf and how the charges were processed. There are many insurance carriers that will not supply the providers detailed claim status; they will only speak to the insurance carrier member or the patient. Consequently, it becomes the patient's responsibility to work closely with the provider to obtain reimbursement for services rendered. This will ensure that you will not be billed for charges that should have been paid by your insurance carrier.

IVY REHAB asks that if you receive an "EOB" from your insurance company for any of the following reasons please proceed as directed below:

1. ***An "EOB" with a check attached for services rendered at an IVY Rehab facility***:
    a. ***Endorse*** (sign) the back of the check
    b. Make a ***copy*** of the "EOB" and the check
    c. ***Send*** the original check and the "EOB" to ***IVY REHAB Central Business Office: 1377 Motor Parkway, Suite 307, Islandia, NY 11749*** or you can bring the original check and the "EOB" to one of our IVYREHAB facilities and the Front Desk Representative will make you a copy and send the originals to the Central Business Office to apply to your account accordingly.

2. ***An "EOB" denying submitted charges:***
    a. ***Call our IVY REHAB Central Business Office 631/580-5200 or 866/489-7342 (866) IVY REHAB*** to speak with an Account Representative ***and fax the "EOB" to 631/580-5222*** or you can bring the "EOB" to an IVYRehab facility and the Front Desk representative will fax the "EOB" to the Central Business Office on your behalf.

3. ***An "EOB" requesting medical records or a letter of medical necessity:***
    a. ***Call*** our ***IVY REHAB Central Business Office 631/580-5200 or 866/489-7342 (866) IVY REHAB*** to speak with an Account Representative and ***fax the "EOB" to 631/580-5222*** or you can bring the "EOB" to an IVYRehab facility and the Front Desk representative will fax the "EOB" to the Central Business Office on your behalf.

Please sign and date this form confirming you have been informed of **IVY REHAB's** policy regarding insurance carrier claims processing and your account resolution:

Please refer all of your billing questions to the **IVY REHAB** Central Business Office and speak to an Account Representative, in order to resolve any account issue that may arise. We thank you for your cooperation and efforts in working with us.

I (Rep Name) _____ have given and explained the above process to .

Patient Signature: _____ Date: _____

Rep Signature: _____ Date: _____

ivyrehab
PHYSICAL THERAPY

ASSIGNMENT OF BENEFITS

I assign to **IVYREHAB Network, Inc** all of my benefits and rights under any insurance contracts for payment of services rendered to me by **IVYREHAB Network, Inc** I authorize all information regarding my benefits under any insurance policy related to any claim to be released to **IVYREHAB Network, Inc**; I authorize **IVYREHAB Network, Inc** to file insurance claims on my behalf for services rendered to me. I direct that all such payments go directly to **IVYREHAB Network, Inc**. I authorize **IVYREHAB Network, Inc** to act in my behalf and report any suspected violations of proper claims practice to the proper regulatory authorities.

I authorize **IVYREHAB Network, Inc** to obtain counsel and enter into legal or other action on my behalf and/or in my name, including the arbitration/dispute resolution process, to collect such sums due, should the sums not be paid within the legally prescribed timeframe. In the event that **IVYREHAB Network, Inc** elects to bring a lawsuit or petition for arbitration/dispute resolution against the insurance carrier. I assign my rights and interest under the medical expense benefits and/or PIP section of any insurance policy under which I am entitled to proceed for benefits. This assignment shall allow an attorney of **IVYREHAB Network, Inc** choosing to bring suit or submit to arbitration/dispute resolution their claim for any unpaid bills for services rendered for injuries that I sustained in this or any accident.

In the event that this assignment is held invalid for any reason, I hereby authorize **IVYREHAB Network, Inc** to appoint an attorney of this choice to represent me directly against an insurer from which I may collect PIP benefits and to bring a claim in a forum of his choice. This appointment is intended to enable the attorney to collect the bills of **IVYREHAB Network, Inc**

I agree and acknowledge that I may receive checks directly from the insurance carrier for services rendered by the provider. I agree to immediately forward said checks to **IVYREHAB Network, Inc** upon receipt.

A photocopy of this assignment shall be as valid as the original. This assignment of benefits has been explained to my full satisfaction and I understand its nature and effect.

Patient Signature: _____ **Date:**_____

ivyrehab
PHYSICAL THERAPY

2018 MEDICARE OUTPATIENT THERAPY EXPLANATION

To all our Medicare patients at IvyRehab,

Beginning January 1, 2018 there will be a ***threshold of* $2010 *per year*** *for* PT and Speech-language pathology together. A separate threshold of $2010 per year is allowable for Occupational Therapy Services.

Medicare will pay out of 80% ($1,608) of their allowable charges ($2010) and you: the patient is responsible for your annual deductible of $183 and the 20% coinsurance of $219.

Please keep in mind **not** all secondary policies will cover the deductible, coinsurance of 20% or additional visits after the threshold has been reached for 2018.

During your treatment period at **IvyRehab,** please check with the front office to make sure you are not going over your therapy allowance. **IvyRehab** has put in place a pre-determined amount of visits that will give you the patient, a comfort level to be able to make informed decisions whether to continue physical therapy according to your financial ability.

There are certain insistence that may allow for coverage beyond the threshold. Your therapist will make that determination and advise you accordingly. If your PT does not see additional treatment necessary beyond the threshold amount you will be given the option of continuing physical therapy at a self pay rate of $75.00 per visit.

For clarification on your secondary policy benefits, please contact your carrier or please feel free to contact our Central Business Office regarding your benefit and financial obligations at:
1-866-IvyRehab

Each beneficiary who uses therapy services will find the total dollar amount that was approved and paid toward the threshold on each Medicare Summary Notice sent to you by Medicare, that reports payment for therapy services. Beneficiaries: call 1-800-MEDICARE with questions.

Please sign and date this form that you have been informed of **IvyRehab's** policy regarding the Medicare Procedure for 2018.

Patient Name:

Patient Signature: _____ **Date:** _____

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated
  - For inquiries:
    Director of Health Information Management
    1377 Motor Parkway, Suite 307
    Islandia, NY 11749

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Ask us to correct your medical record
- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.
- Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

(Continued on reverse)

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.
- Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.
- We will use your email and other contact information to provide appointment reminders and information about your care, before and after your treatment.
- Example: We use health information about you to manage your treatment and services.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.
- Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- Other federal and state laws may require special privacy protections that limit the use and disclosure of certain health information about you. For example, such laws may include restrictions on the use and disclosure of genetic information, alcohol, and drug abuse information, HIV/AIDS, mental health, and sexually transmitted diseases. It is our intention to adhere to the more stringent legal requirement when this type of information is used or disclosed.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date: September 1, 2017