# CENTER REHAB

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ORTHOPEDIC SPORTS PHYSICAL THERAPY EVALUATION & TREATMENT

155 HILL STREET
MILFORD CT 06460
WWW.CENTERREHAB.COM
PHONE: 203-882-9384
FAX: 203-882-9385

Thank you for choosing Center Rehab. This package is designed to make getting started on your recovery easy. By printing and completing these forms, you can save time and check to be sure the information is correct. Here are a few tips before you arrive:

- ☑ Bring your completed forms with you.
- ☑ Arrive 10 to 15 minutes early the first day.
- ☑ Parking is located in a smaller lot in front of the office door. Look for our sign on the building. Additional space is located in a larger lot nearer to the corner.
- ☑ Wear comfortable clothing such as shorts or loose pants and a t-shirt. Avoid skirts, heels, jeans and dress clothes. You are welcome to bring a change of clothes with you if you are coming from or going to work.
- ☑ Bring your physical therapy prescription with you from the doctor.
- ☑ Bring your insurance card or auto policy info and a picture ID.
- ☑ We run very close to scheduled times, so please be prompt.
- ☑ Plan to spend an hour with your therapist on your first visit.

# CENTER REHAB

**PLEASE ARRIVE 10-15 MINUTES EARLY ON THE FIRST DAY**

**FROM MERRITT PARKWAY:**

- ☑ EXIT 54 AND FOLLOW THE CONNECTOR TO THE 3RD EXIT.
- ☑ GO THROUGH THE STOP SIGN TO THE TRAFFIC LIGHT.
- ☑ TURN RIGHT ON TO THE BOSTON POST ROAD (ROUTE 1) AND DRIVE ABOUT 1 MILE.
- ☑ TURN LEFT ON TO WEST CLARK STREET AT GUSTO RESTAURANT.
- ☑ TURN RIGHT AT THE SECOND STOP SIGN ON TO HILL STREET.
- ☑ WE ARE THE FIRST BUILDING ON THE LEFT. TURN INTO THE THIRD DRIVEWAY.

**FROM I 95:**

- ☑ EXIT 36 (PLAINS ROAD).
- ☑ TURN **RIGHT** ON TO PLAINS ROAD IF YOU WERE TRAVELING I95 NORTH OR **LEFT** IF YOU WERE TRAVELING I95 SOUTH.
- ☑ TRAVEL STRAIGHT ACROSS THE BOSTON POST ROAD (ROUTE 1) ON TO WEST CLARK STREET.
- ☑ TURN RIGHT AT THE SECOND STOP SIGN ON TO HILL STREET.
- ☑ WE ARE THE FIRST BUILDING ON THE LEFT. TURN INTO THE THIRD DRIVEWAY.

**FROM THE MILFORD GREEN AREA:**

- ☑ FROM THE MILFORD GREEN DRIVE PAST MILFORD HOSPITAL ON BRIDGEPORT AVENUE.
- ☑ TURN RIGHT ONTO CLARK STREET (AT MR. MAC'S / CARVEL ICE CREAM).
- ☑ FOLLOW CLARK STREET OVER THE RAILROAD TRACKS.
- ☑ TURN LEFT AT THE FIRST STOP SIGN ONTO HILL STREET.
- ☑ WE ARE THE FIRST BUILDING ON THE LEFT. TURN INTO THE THIRD DRIVEWAY.

**FROM THE BOSTON POST ROAD (RT 1):**

- ☑ TURN ONTO WEST CLARK STREET AT GUSTO'S RESTAURANT.
- ☑ TURN RIGHT AT THE SECOND STOP SIGN ON TO HILL STREET.
- ☑ WE ARE THE FIRST BUILDING ON THE LEFT. TURN INTO THE THIRD DRIVEWAY.

203-882-9384 155 HILL STREET, MILFORD CT 06460

# Insurance Information

**Private insurance will not pay for treatment of a workplace injury. You must first file for workers compensation coverage.**

## To Be Completed By The Patient

Name of Patient_____

Home Address _____

PO Box for Mailings: (if needed)_____

City_____ State_____ Zip_____ Birthdate_____/ _____/ _____

S.S. #_____ Cell/Home Phone_____ Work Phone_____

Employer_____

Spouse's Name/Emergency Contact _____#_____

How did you hear of Center Rehab? □Web Search □Yelp □Doctor □Friend □Facebook □Yellow pages

We ask that all Insurance source benefits are paid directly to Center Rehab **YES** / No
(If no, then payment is due on date of visit)

## To Be Completed By The Policy Holder If Different

Name of Insured_____ Date of Birth_____/ _____/ _____

Home Address (no PO Boxes)_____

## Complete For Workers Compensation Only

Employer/Address_____

Employer Contact Person_____ Phone_____

Case Number_____ Case Worker_____

Insurance Company_____

Address_____

**The Above Information Is Complete And Accurate:**

**Signature**_____ **Date**_____
**(Guardian if patient under 18 or responsible person)**

Revised 11-19-14

# Center Rehab Confidential Patient Medical History

**Name:** _____ **Date:** _____

**Age:**_____ **Height:**_____ **Weight:**_____

**Why did you come to see a Physical Therapist?** _____

| **Have You Recently Had:** | **Circle One** | **Comments** |
|---|---|---|
| Weight Loss / Gain? | Yes / No | |
| Loss of appetite? | Yes / No | |
| Unexplained fevers / chills/ sweats? | Yes / No | |
| Fatigue / tiredness? | Yes / No | |
| Urinary or bowel problems? | Yes / No | |
| Nausea and vomiting? | Yes / No | |
| Numbness or tingling? | Yes / No | |
| Coordination problems? | Yes / No | |
| Difficulty walking? | Yes / No | |
| Dizziness or loss of consciousness? | Yes / No | |
| Loss of balance or falls? | Yes / No | |
| Chest pain or palpitations? | Yes / No | |
| Shortness of breath? | Yes / No | |
| New onset of headaches? | Yes / No | |
| Visual problems? | Yes / No | |
| Hearing problems? | Yes / No | |
| | | |
| **Have you been told that you have**: | **Circle One** | |
| High blood pressure? | Yes / No | |
| Heart problems (including pacemaker)? | Yes / No | |
| Lung problems? | Yes / No | |
| Kidney problems? | Yes / No | |
| Head injury? | Yes / No | |
| Multiple Sclerosis / Parkinson's Disease? | Yes / No | |
| Stroke / Neurological problems? | Yes / No | |
| Liver problems? | Yes / No | |
| Thyroid problems? | Yes / No | |
| Blood disorders or anemia? | Yes / No | |
| Diabetes (high blood sugar)? | Yes / No | |
| Low blood sugar? | Yes / No | |
| Seizures? | Yes / No | |
| Cancer? | Yes / No | |
| Arthritis? | Yes / No | |
| Tuberculosis? | Yes / No | |
| Lyme's Disease | Yes / No | |

| **Have you been told that you have:** | **Circle One** | **Comments** |
|---|---|---|
| Repeated infections/immune problems? | Yes / No | |
| Osteoporosis? | Yes / No | |
| Circulation or vascular problems? | Yes / No | |
| Broken bones/fractures? | Yes / No | |
| Ulcers/stomach problems? | Yes / No | |
| Do you smoke? | Yes / No | |
| | | |
| **For Men Only**: | | |
| Prostate Problems? | Yes / No | |
| **For Women Only**: | | |
| Gynecological/Pelvic problems? | Yes / No | |
| Problems with your period? | Yes / No | |
| Are you pregnant or think you might be? | Yes / No | |
| Complicated pregnancies/deliveries? | Yes / No | |

Do you have any other medical problems? Please List_____

_____

What prescription and non-prescription medications/drugs do you take? _____

_____

Please list any **allergies** to latex, lotions, gels, or any medication_____

_____

Have you been hospitalized or had surgery in the past? If so, when and for what?_____

_____

Have you seen anyone else for this problem? Please check all that apply.
Physician___ Osteopath (D.O.)___ Physical Therapist____ Chiropractor____ Podiatrist____

Dentist____ Other_____

Have you had recent diagnostic tests? (i.e. X-rays, CT scan, MRI, bone density, stress test etc.)

_____

Who is your primary care physician or the doctor who referred you? _____

Patient Signature Date

## PAYMENT AND BILLING INFORMATION - PLEASE READ CAREFULLY

**NO PORTION OF THIS FORM SHALL BE ANNOTATED OR OTHERWISE ALTERED BY THE PATIENT OR POLICY HOLDER.**

**Your Insurance:** Please know your policy. Co-pays, if required by your insurance, are due at the time of each treatment session. Fees will apply if we have to bill you for co-pays or other time-of-service payments. Your insurance plan may require that we seek their approval to begin treatment. You agree to allow us to bill your insurance company or payment source and authorize all payments for services to be made directly to Center Rehabilitation & Sports Therapy. You may self-pay for all treatment charges yourself if you wish.

**Auto Injury Cases:** In cases involving motor vehicle accident related injuries, we will need insurance information on your vehicle. You need to provide your private insurance information as well. We will help determine eligibility. If a lawyer is representing you, we will need that person's name. Co-Pays or deductibles are due with each visit if you use your health insurance, even if you have a lawyer involved. If you have a suit or other questions, please talk with the office staff.

**Balances:** Any balance which is not covered by your payment source(s) and is properly determined to be the responsibility of the insured and/or treated individual will be billed by USPS by this office. All balances are due within 30 days of our billing. No interest payment plans can be arranged by our billing office. A monthly late fee of 20% will apply to delinquent balances. The undersigned will be responsible for reasonable fees and other costs of suit or collection on delinquent balances. Returned checks will be assessed an additional penalty of 50% of the amount plus bank fees.

**Appointments:** Please give us the courtesy of 24 hours notice for cancellation and rescheduling of your appointment. We understand that sometimes you must miss a scheduled appointment because of circumstances beyond your control. Please call us as soon as you can if you are not able to keep an appointment. More than 2 late cancellations or "No-Show" episodes shall result in a $50.00 charge being applied to your account. Also, future visits shall be cancelled. Arriving late means less time with your Therapist. Try to call so we know you are coming.

**I have read, understand and agree to the statements above:**

**Patient Signature**_____ **Date**_____

**(Responsible person if patient is under 18)**

**Revised 2-1-15**

# CENTER REHABILITATION & SPORTS THERAPY LLC

## Authorization For Medical & Personal Information Release

I hereby authorize Center Rehabilitation & Sports Therapy LLC, to release my medical records and personal data including all information regarding my condition, bills, records, diagnosis and prognosis only to those entitled to this information as required by insurance contract, law, other third party payers, or as ordered by State or Federal Court. If this is a workers compensation case, your employer is entitled to this information by law. This information will be handled and protected from unauthorized disclosure in a manner specified by Federal and State privacy laws.

Further, you authorize at this time, your Doctor or other medical specialist, laboratory or diagnostic imagining center to release medical records, test results and imaging information to Center Rehabilitation & Sports Therapy which are necessary to treat your condition properly.

Finally, you authorize Center Rehabilitation & Sports Therapy LLC to communicate regularly with your doctor(s) and their office(s) to ensure coordinated care via direct consultation, phone calls, faxed/mailed written correspondence and encrypted email.

Medical and personal information in our files will be provided to those not mentioned above only if we receive additional authorization for such release signed by you or your legal guardian. Please allow 48 hours notice for copies.

A photocopy or facsimile of this form will be considered valid and enforceable.

**What phone number would you prefer we leave messages or appointment

reminders? _____Cell/Home/Work

**Print Patient Name**_____

**Signature**_____ **Date**_____

**(Guardian if patient under 18 or responsible person)**

Revised 11-19-14