PATIENT REGISTRATION

Welcome to **MultiCare Therapy Center**. In order to serve you properly, we will need the following information.
(Please Print) All information will be strictly confidential.

Patient's Name Last First Middle	**Sex** M F	Birth Date ______/______/_______ Age_________	**Marital Status** Single [ ] Married [ ] Widowed [ ] Divorced [ ]
Residence Address City State Zip			Patient's Social Security #

Home phone	Work phone	Cell or other phone	e-mail address
Name of employer Address **or _____ Not Applicable**			Occupation

Reason for Visit	Referred By: (Include address and phone)

Person to Contact in Case of Emergency:	Relationship to Patient:	Phone #:

Primary Insurance **ID Number** **Effective Date**	**Policy Holder Relationship to patient** [ ] self [ ] spouse [ ] Other___________________________

Policy Holder's Name	**Policy Holder's Birthdate** ____/____/_____	**Policy Holder's Employer**	**Employer Tel #**

Secondary Insurance **ID Number** **Effective Date**	**Policy Holder Relationship to patient** [ ] self [ ] spouse [ ] Other___________________________

Secondary Insurance Policy Holder's Name	**Policy Holder D.O.B.**	**Policy Holder's Employer**	**Employer Tel #**

Motor Vehicle Accident? Yes **[ ]** No **[ ]**	Date of Accident	Claim #
Name of Insured (auto owner)	Insurance Company Name	

Workman's Comp? Yes **[ ]** No**[ ]**	Date of Accident	Case/Carrier #	Name of Union, if member
Name of Employer	Employer Tel #		Union Tel #

I guarantee that the information I have provided here is true and accurate. I hereby authorize benefits payment directly to MultiCare Therapy Center and acknowledge that I am financially responsible for any unpaid balance.

____ ________________________

Patient, Parent or Guardian Signature (if child is under 18 years old) Date

MultiCare Therapy Center
PATIENT MEDICAL HISTORY FORM

Patient Name:____

1. Have you ever suffered from?

	Yes	No
Heart Disease	_	_
High Blood Pressure	_	_
Heart Attack	_	_
Emphysema	_	_
Asthma	_	_
Blood Disease	_	_
Kidney Disease	_	_
Glaucoma	_	_
Diabetes	_	_
Jaundice/Hepatitis	_	_
Cancer	_	_
Anemia	_	_
Bruise easily	_	_
HIV	_	_
Facial Trauma	_	_
Allergies	_	_
Circulatory Problems	_	_
Cardiac Problems	_	_
Pacemaker	_	_
Low Blood Pressure	_	_
Hearing Problems	_	_
Vision Problems	_	_
Balance Problems	_	_
Seizures	_	_
Syncope	_	_

2. What Medications are you currently taking? ____________________________
____
____

3. List any medical problems: ________
____
____

5.What medications are you allergic to? _______________
____

6. What is your primary physician's name and when was your last physical examination?
Name of Physician:__________________________________
Address: ____
____

7. Have you had a recent :

	Normal	Abnormal	Yes	No
Chest x-ray	____	____	__	__
Electrocardiogram	____	____	__	__

8. Have you ever had any previous surgery? ____________
What kind/When/Where? __________________________
____
____
____
____

9. Have you ever consulted a professional for emotional problems? Who/When? ____________________
____

10. Do you have any caps, crowns, bridges, loose, or false teeth? ____Yes ___No

11. Do you have any metal implants or pacemaker?
(what/where)____

12. Do you have any of disease or problem not listed you feel that we should know about? ______________
____
____
____

4. Do you have any of the following habits?

	Yes	No		
Smoking	___	___	Frequency________________	Years__________
Alcohol	___	___	Frequency________________	Years__________
Recreational Drugs	___	___	Frequency________________	Years__________

Patient Signature:_________________________________ Date:________________

MultiCare Therapy Center - Medicare Secondary Payer Questionnaire

Patient's Name_______________________________________ Date:________________

Medicare #:______________________________________ Date of Birth:______________

I am

OVER 65

❑Married ❑ Not married ❑ Widowed ❑Retired as of_____________________

❑Employed full- or part-time with a company with: ❑Never employed

❑Fewer than 20 employees ❑More than 20 employees *(enter insurance info on Registration Form)*

(If married) My spouse is: ❑Retired as of _______________________

❑Employed full- or part-time by a company with: ❑Never employed

❑Fewer than 20 employees ❑More than 20 employees *(enter insurance info on Registration Form)*

I am under 65, disabled, and:

❑HAVE ❑DO NOT HAVE health care coverage through a LGHP with an employer with 100 or more employees

❑HAVE ❑DO NOT HAVE health care coverage through anyone else

❑I have *End-Stage Renal Disease*

❑I am entitled to *Black Lung Benefits* (date benefits began__________________)

❑I am entitled to *Veterans' Benefits*

❑*COBRA* benefits apply Plan, group #, ID#____

❑I was *injured in an accident*

Date of accident____________________ ❑Work-related ❑Non- work-related

Describe accident____

____

Responsible party/plan/policy____

____

❑My services are being paid for a *government program*, such as a research grant

Details:____

Please give any additional information related to the above questions:______________________

____

____

____

____

____ ________________

Signature of Patient Date

Revised 1.24.06

MultiCare Therapy Center

Advanced Directives/”Living Will”//DNR Forms
Patient Information/Acknowledgement

Please be advised that MultiCare Therapy Center has an emergency policy and procedure which indicates that 911 will be called for all patient emergencies. We request that all patients, upon admission, supply MultiCare Therapy Center with copies of their Advanced Directives to retain in their medical chart so that in the event of a 911 emergency we can give your directives to the Emergency Transit Team.

Do you have an Advanced Directive/”Living Will”/DNR instructions? _____yes _____no

Copies provided to MultiCare Therapy Center? _____yes _____no

______________________________________ ______________

Patient Signature Date

MultiCare Therapy Center
1527 Route 27, Suite 1500 Somerset, NJ 08873 732-545-7474 fax 732-545-2880

Authorization for Release/Receipt of Information

Patient Name____ Date__________________

I authorize the physicians/hospitals listed below to release my medical records to MultiCare Therapy Center.

(List current Physicians – Hospitals)

1. ____

2. ____

3. ____

4. ____

5. ____

I authorize MultiCare Therapy Center to release my Medical Records to the above mentioned Physicians/Hospitals.

READ CAREFULLY: I understand that my medical records are confidential. I understand that by signing this authorization I am allowing the release of my medical information requested to the agency or persons specified above. Drug and alcohol abuse information records are specifically protected by federal regulations and by signing this authorization, I am allowing the release of any drug, alcohol, and/or psychiatric information records to the agency or persons specified above. I understand that my records may contain information regarding the diagnosis and treatment of HIV (AIDS virus) and other sexually transmitted diseases and by signing this authorization, I am allowing this information to be released to the agency or persons specified above. I also understand that I may revoke this authorization at any time by written request from myself or my family except to the extent that action has already been taken in reliance upon it.

This consent shall remain in effect for ninety (90) days from the date executed unless revoked earlier by me. If revoked earlier, it is understood by all parties that the information released prior to being notified of such revocation was made at my request with my consent.

I have read the above and foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this consent.

Date:_____________ Signature: ____
(If signed by personal representative, please state relationship/authority to do so.)

Patient Name: ___________________________________ Date of Service:_______________

INFORMED CONSENT FOR TREATMENT/PROCEDURE

I acknowledge that **MultiCare Therapy Center** has informed me of the following:

1. My diagnosis, if known
2. My basic rights and responsibilities as a patient
3. The nature and details of the procedure/treatment
4. The purpose of the procedure/treatment
5. The potential risks of the procedure/treatment
6. The potential benefits of the procedure/treatment
7. The alternatives available, if any
8. The risks and benefits of the alternatives
9. The potential risk if the procedure/treatment is not performed

I acknowledge that I have had an opportunity to ask all the questions I have regarding this condition or disease and concerning the available treatments and/or procedures. All questions have been answered to my satisfaction.

I understand that my Treatment Plan will be individualized to me and my needs, and will be created in consultation with my referring physician and the professional personnel of the facility including the Medical Director. This plan will be reviewed every 30 days. I will be invited to attend that review, if I desire, along with a family member or my caregiver. I give consent for MultiCare Therapy Center to discuss my case with the people I invite to attend these periodic reviews of my case.

I acknowledge that no guarantees, either express or implied, have been made to me regarding the outcome of any treatments and/or procedures. I fully understand that it is impossible to make any guarantees regarding a cure or outcome of any medical treatment or procedure.

I hereby authorize the above-named provider and designated associates and assistants to perform the treatment(s) or procedure(s) named above.

____ _______________

Authorized Signature Date

FEMALES ONLY

I hereby declare that as of the date above, to the best of my knowledge, I am not pregnant. In the event that I should discover that I am pregnant, I will inform MultiCare Therapy Center. I do not hold MultiCare Therapy Center liable for any complications that may arise due to treatment.

____

Signature

MultiCare Therapy Center - Release of Information

Patient Name (Please print)____

Instructions: **Please read this form carefully, check applicable spaces, and sign.**

Insurance Authorization-Patient Release and Authorization:

____ I hereby give lifetime authorization for payment of insurance benefits made directly to MultiCare Therapy Center and any assisting physicians, for services rendered, I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all cost of collection and reasonable attorneys fees. This information will be used for the purpose of evaluating and administering claims of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

____ I further authorize the release of any medical information required by my insurance carrier(s)

____ I also authorize the release of test data and billing information to a licensed physician of the facility's choosing for the purposes of professional interpretation and establishment of a diagnosis and treatment recommendations.

Medicare Authorization-Patient Release and Authorization

____ I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.

____ I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information 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.

Authorization for home communication

____ I authorize MultiCare Therapy Center to leave messages regarding my scheduled appointments on my home answering machine

____ I authorize MultiCare Therapy Center to leave messages regarding my scheduled appointments with members of my household

___ I was offered a copy of the procedure for filing a grievance.

___ I was given a copy of the HIPAA Privacy Practices Notice

___ I was given a copy of the Patient Rights

PATIENT_________________________________ DATE_______________________

FOR PATIENT_____________________________ DATE_______________________

Notice: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal Law.

MultiCare Therapy Center

HIPPA
Notice of Privacy Practices

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

Name____ Date____________________________

Protected Information: While receiving care from our facility, information regarding your medical history, treatment, and payment for your health care may be originated and/or received by us. Information which can be used to identify you and which relates to your past, present or future medical condition, receipt of health care or payment for health care ("Protected Information").

Our Responsibilities: Federal law imposes certain obligations and duties upon us as a covered health care provider with respect to your Protected Information. Specifically, we are required to:

- Provide you with notice to our legal duties and our facility's policies regarding the use and disclosure of your Protected Information;
- Maintain the confidentiality of your Protected Information in accordance with state and federal law;
- Honor your requested restrictions regarding the use and disclosure of your Protected Information unless under the law we are authorized to release Protected Information without your authorization, in which case you will be notified within a reasonable period of time;
- Allow you to inspect and copy your Protected Information during our regular business hours;
- Act on your request to amend Protected Information within sixty (60) days and notify you of any delays which would require us to extend the deadlines by the permitted thirty (30) days extension;
- Accommodate reasonable requests to communicate Protected Information by alternative means or methods; and
- Abide by the terms of this notice.

How your Protected Information Can Be Used and Disclosed: Generally, your Protected Information may be used and disclosed by us only with your express written authorization. However, there are some exceptions to this general rule.

Treatment, Payment or Health Care Operation: Treatment Purposes. We may disclose your Protected Information for various treatment purposes. During your care at our facility, it may be necessary for various personnel involved in your case to have access to your Protected Information in order to provide you with quality care. In addition, we may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services which may be of interest to you.

***Please note:** We reserve the right to revise our practices with respect to Protected Information and to amend this notice. Should our information practices change, we will post notice of the change in the waiting area of this facility. In addition, current notice of our privacy practices mey be obtained from Philip Chiyuto, Clinic Administrator at 732-545-7474.