Howard Liss, MD Rehabilitation Institute

Registration Date____________________

Last Name	First Name	Middle Init	Sex
Address	City	State	Zip

Home Tel Bus Tel Cell

Date of Birth	Age	SS#	No. of Children	Children's Age(s)

Email

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow(er)	Live: ☐ Alone ☐ With	No. of stairs to bedroom	No. of stairs outside

Employer Name	Occupation
Emp. Address	Emp. Tel
Referred By	
Referring Physician	Telephone
Other Treating Physicians	Telephone
Family Physician	Telephone

Emergency Contact	Relationship	Telephone
Race: ☐ White ☐ Asian ☐ African American ☐ Other	Primary Language: ☐ English ☐ Hebrew ☐ Russian ☐ Spanish ☐ Korean ☐ Chinese	Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Social History: Packs of cigarettes / day	Use of recreational drugs ☐ Yes ☐ No	#of alcoholic drinks per week

Past Medical History
☐ Diabetes ☐ High Blood Pressure ☐ Increased Cholesterol ☐ Heartburn ☐ Heart disease
☐ Cancer ☐ Asthma ☐ Lung Disease ☐ Kidney Disease ☐ Ulcer ☐ Osteoporosis
☐ Other____

Major Surgeries / date
1) 4)
2) 5)
3) 6)
7)

Current Medications w dosage			Allergies to medication - list
1)	4)	8)	
2)	5)	9)	
3)	6)	10)	
	7)	11)	

☐ Right handed	☐ Left handed	Height	Weight

Physical Demands at:	Home	Work

Sports	Hobbies	Exercises

Did you have phisycal/occupational therapy elsewhere this calendar year? ☐ Yes ☐ No

If yes, for what condition? ____

At which facility? ____

Do you have home nursing, a home aide of home therapy? ☐ Yes ☐ No

Family history: are they any immediate family members with the following: (F – Father, M – Mother, S - Sibling)

☐ Diabetes	☐ Heart disease	☐ Cancer	☐ Back problems
☐ Neck problems	☐ Joint problems	☐ Neurological disorder	☐ Other family

☐ Please initial this box to allow the doctor to access your prescription history form your pharmacy.

Pharmacy name: Address: Phone:

ACCIDENT INFORMATION REHAB RN________________________ Telephone# ___________________

☐ MVA ☐ Workers' Compensation ☐ Date of Accident______________________________

Name of Insurance Company:____
Adjuster:____ Phone #:_______________________________
Claim #:____
Employer at time of injury:____
Attorney's Name:_____________________________________ Attorney's Phone #: _______________________
Attorney's Address:____

Have you filled out & returned your PIP application? ☐ ***Yes*** ☐ ***No***

Has your employer filed an accident report? ☐ ***Yes*** ☐ ***No***

Insured's name if not the same: ____

Address____

Street City State Zip Code

Telephone____ Business Telephone___________________________

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ________________________

Medicare? ☐ Yes ☐ No If Yes: Number _______________ Eff. Date_____________ ☐ Part A ☐ Part B

Insured Individual or Spouse Information: Name ____
Relationship to patient:____________SS# ____________ Date of Birth_____________ Telephone_______________
Primary Insurance ____
Policy #____ Group #_______________________________________
Address ____Telephone # ___________________________________
Secondary Insurance____
Policy #____ Group #_______________________________________
Address ____Telephone # ___________________________________

Assignment of Benefits (Medicare/Private Patients):
I authorize payment of medical benefits directly to Howard Liss, MD Rehabilitation Institute, for service described. I accept full responsibility for total amount of bill.

Signature____Date ________________________

I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administrations or their intermediaries or carries, or to the billing agent of this physician, any 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.

Signature____Date ________________________

FOR YOUR INFORMATION: Your appointment is reserved exclusively for you. Please be on time for your appointments. As a courtesy to those patients waiting for appointments, 24 hour notice is required to cancel your appointment. Failure to adhere to this policy may result in a $50.00 charge.

PRIVATE INSURANCE: If provided with your insurance information and copy of your insurance card, we will process the claim for you and provide all the necessary paperwork to accompany your claim. If your insurance company is slow to pay or denies the claim, it your responsibility to follow up with them. HOWEVER, YOU ARE RESPONSIBLE FOR YOUR CO-PAYMENT AND ANY DEDUCIBLE AT THE TIME OF SERVICE AND/OR ANY REMAINING BALANCE NOT COVERED BY YOUR INSURANCE.

MEDICARE: We will submit your claim to Medicare. We accept Medicare assignment; therefore payment will come directly to us However, you are still responsible for the 20% co-pay of what Medicare approves. If you have a secondary insurer, please be sure to provide us with a copy of your insurance card so we can submit to your secondary carrier.

NO- FAULT INSURANCE: If your claim was verified prior to your appointment, we will submit the bill, to your insurance carrier in lieu of payment at time of service. We expect you to promptly complete and mail to your insurance carrier your PIP from and any other necessary paperwork needed by the carrier to process your claim YOU WILL BE RESPONSIBLE FOR ANY DEDUCTIBLE AND CO-PAYMENT. If you have a secondary insurance to cover this balance, it is up to you to file the claim.

WORKER'S COMPENSATION: If you are being seen due to a work related injury, we will file with your compensation carrier – We expect you to provide us with the complete information to properly process your claim – If the insurance carrier denies the claim, you are responsible for the outstanding balance.

SIGNED____Date ____________________________

Howard Liss, MD Rehabilitation Institute

Date________________ Name:____________________________________

REVIEW OF SYSTEMS

CONSTITUTIONAL	Circle One
Do you have fevers, sweats or chills?	Yes No
Do you have trouble with your appetite?	Yes No
Have you had more than a 10 lb. change in weight in the last year?	Yes No
Do you frequently feel tired?	Yes No

SKIN	
Do you have any skin rashes, sores or itching?	Yes No
Do you have any moles or beauty marks that are changing or troubling you?	Yes No

EYES, EARS, NOSE AND THROAT	
Do you have eye problems or trouble with your vision?	Yes No
Do you have any ear problems or trouble with your hearing?	Yes No

RESPIRATORY	
Do you have a persistent cough or phlegm?	Yes No
Do you have any wheezing?	Yes No
Do you have trouble breathing?	Yes No

CARDIAC	
Do you have high blood pressure?	Yes No
Do you have height cholesterol?	Yes No
Do you have pain or tightness in your chest?	Yes No
Have you had a cardiac stress test? Date ________	Yes No
Reason of cardiac stress test: ________________	Yes No
Results of cardiac stress test: ☐ Normal ☐ Abnormal Have ____	Yes No
you had an abnormal EKG?	Yes No
Have you had palpitations?	Yes No
Have you had dizziness, light headedness or faintness?	Yes No
Have you had a heart attack?	Yes No
Have you had heart disease or any heart condition?	Yes No
Do your ankles swell?	Yes No

GASTROINTESTINAL	
Do you have any difficulty swallowing?	Yes No
Do you have any stomach pains, heartburn or vomiting?	Yes No
Do you have constipation or use laxatives often?	Yes No
Do you have frequent diarrhea?	Yes No
Have you had any black or bloody bowel movements?	Yes No
Has there been any change in the color, size or consistency of your bowel movements recently?	Yes No

OSTEOPOROSIS	
Have you had bone density testing? Date ________	Yes No
Results: ☐ Normal ☐ Osteopenia ☐ Osteoporosis	

GENITOURINARY	Circle One
How many times a night do you urinate? ________	
Do you have trouble stopping or starting urinating?	Yes No
Do you ever lose your urinate accidentally?	Yes No

WOMEN WITH MENSTRUAL PERIODS	
Date last menstrual period began ____________	
Do you have any vaginal bleeding between periods or after intercourse?	Yes No

WOMEN WITHOUT MENSTRUAL PERIOD	
Age at last menses: ____________	
Are you bothered by hot flashes?	Yes No
Do you ever have bleeding / spotting?	Yes No

ALL WOMEN	
Do you have any lumps, discharge or pain with your breasts?	Yes No

MEN	
Do you have any discharge from your penis?	Yes No

NEUROLOGIC	
Are you bothered by frequent headaches?	Yes No
Do you have fainting or falling out spells?	Yes No
Do you fall or have trouble with your balance?	Yes No
Do you have any numbness, tingling or weakness in your arms or legs?	Yes No
Have you had any serious trouble with your memory?	Yes No
Have you had strokes, seizures or epilepsy?	Yes No
Do you snore?	Yes No
Do you experience daytime drowsiness?	Yes No
Do you gasp for breaths at night?	Yes No
Do you have trouble falling asleep?	Yes No

HEMATOLOGIC	
Do you have a low blood count?	Yes No
Do you have bruise or bleed easily?	Yes No

ALLERGIC/IMMUNOLOGIC	
Do you have any allergies?	Yes No
Do you have any swollen glands?	Yes No

PSYCHIATRIC	
Do you often feel depressed or sad?	Yes No
Are you upset or nervous more than you feel you should be?	Yes No
Do you have trouble sleeping?	Yes No

Howard Liss, MD Rehabilitation Institute

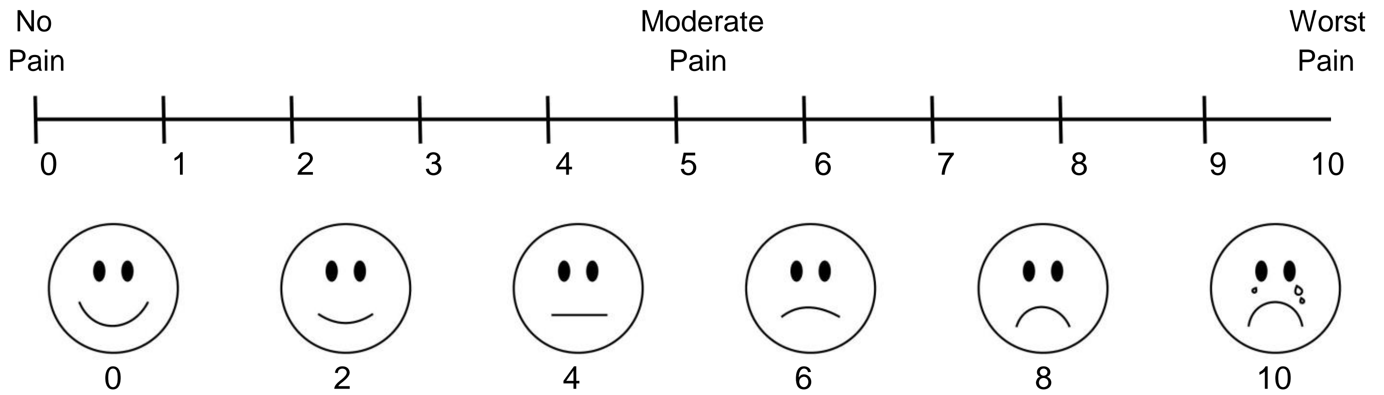
Date________________ Name:____________________________________

Activities of Daily Living

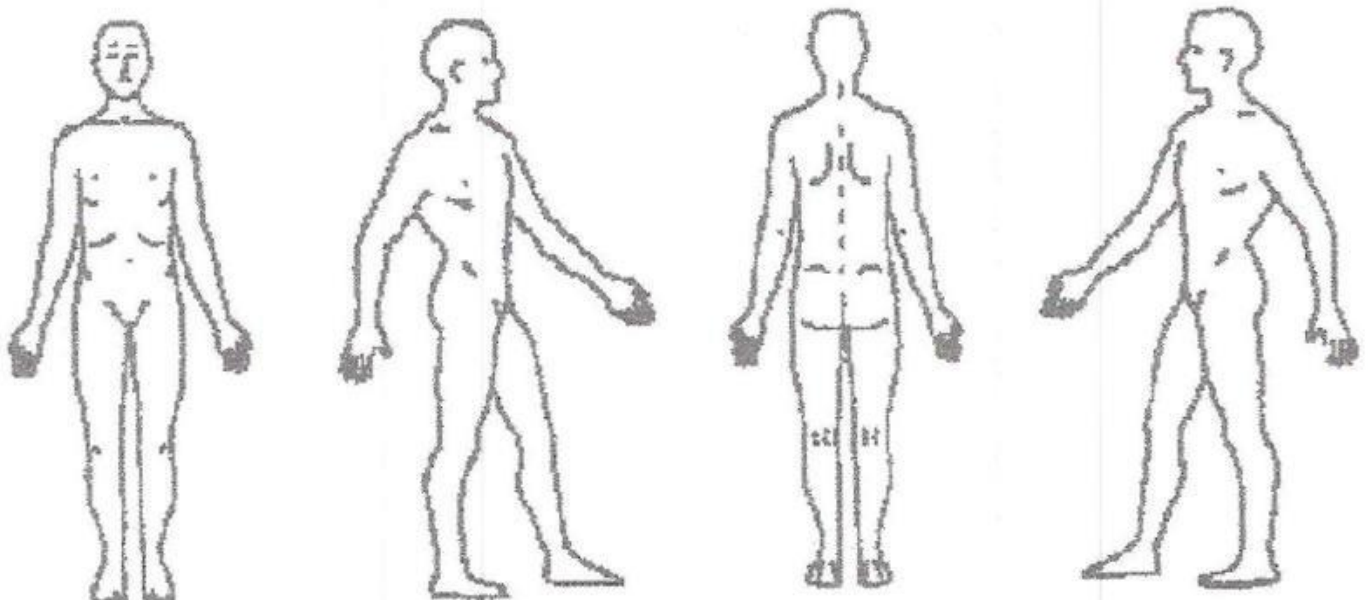
Do you have difficulty performing any of the following or pain when performing any of the following?

	No Problem	Able with Pain (describe)	Difficulty (describe)
Sitting			
Arising			
Driving			
Exercise			
Walking			
Stairs			
Cooking			
Grooming			
Dressing			
Feeding			
Other			

IF YOU HAVE PAIN, PLEASE FILL IN THE FOLLOWING:
Please indicate here on this line your overall level of pain is:



Shade in areas of pain



Howard Liss, MD Rehabilitation Institute

HIPPA and Release Form Date: ________________

Name:____ **Date of Birth:**__________________

Release for Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse____

[ ] Child(ren) ______________________________________

[ ] Other ____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Acknowledgement of Receipt

By signing this page, I acknowledge having received the HIPPA notice that describes how medical information about me may be used and disclosed.

Patient Name: ______________________________________

Signature:____

Date: _______________________

If you are not the patient:
Relationship the patient: ________________________

Witness: _________________________

Signed:____ Date:_________________________

Witness: ____ Date:_________________________

HOWARD LISS, MD REHABILITATION INSTITUTE

NOTICE OF PRIVACY PRACTICES

For more information or to file the written, you may contact our Privacy Officer at the following address:

Howard Liss, MD Rehabilitation Institute
ATTM HIPPA Privacy Officer
111 Dean Drive, Suite 1 North
Tenafly, NJ, 07670
Phone: (201) 390-9200
Fax: (201) 503-0844

For more information about HIPPA or to file a complaint:

Secretary of Health & Human Services
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue S.W.
Washington, D.C., 20201
(202) 619-0257, or Toll Free: 1-877-696-6775

HIPPA NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE 14.2003

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

1. We may use or disclose your health information for purposes of treatment, payment or healthcare operations without obtaining prior authorization. Here is one example for each:

We may provide your health information to health care professionals including doctors, nurses, and technicians-for purposes of providing you with care.

Our billing department may access your information and send relevant parts to insurance companies to allow us to be paid for services we rendered to you.

We may access or send information to our attorneys accountants in the event we need the information in order to address one of our business functions.

2. We may also use or disclose your health information under the following circumstances with our obtaining prior authorization.

To notify and/or communicate with your family: unless you tell us you object, we may use or disclose your health information in order to notify your family or assist in notifying your family, personal representative or another person responsible for your care, about your location, your general condition in the event of your death. If you are unable or unavailable to agree or object, our health professional will use their best judgment in any communications with your family or others.

As required by law:

For public health purposes: we may use or disclose your health information to provide information to state of federal public health authorities, as required by law to prevent or control disease, injury or disability; to report child abuse or neglect; report domestic violence; report to the Food and Drug Administration problems with products and reactions to medications; and report disease or infection exposure. For health oversight activities: we may use or disclose your health information to health agencies during the course of audits, investigations, certifications and other proceedings.

In response to the subpoenas or for judicial and the administrative proceedings: we may use or disclose your health information in the course of any administrative or judicial proceedings. However, in general we will attempt to ensure that you have been made aware of the use or disclosure of your health information.

To law enforcement personnel: we may use or disclose your health information to law enforcement official to identify or locate a suspect, fugitive, material witness, or missing person, comply with a court order or subpoena and other law enforcement purposes.

To coroners or funeral directors: We may use or disclose your health information for purposes of communicating with coroners, medical examiners, and funeral directors.

For purposes of organ donation: We may use or disclose your health information for purposes of communication to organizations involved in procuring, banking or transplanting organs and tissues.