DATE _____

PATIENT REGISTRATION

FOR INTERNAL USE ONLY
PATIENT NUMBER _____

PATIENT INFORMATION

SOCIAL SECURITY # _____
FIRST NAME _____ MIDDLE _____
LAST NAME _____
SEX _____ DATE OF BIRTH ____/____/____
MARITAL STATUS ☐ MARRIED ☐ SINGLE
☐ DIVORCED ☐ WIDOWED
(CHECK ONE) ☐ EMPLOYED ☐ RETIRED ☐ FULL TIME STUDENT
☐ OTHER _____
EMPLOYER _____

HOME ADDRESS _____
_____
CITY ST _____ ATE _____ ZIP _____
EMAIL _____
HOME PHONE (_____) _____
WORK PHONE (_____) _____
REFERRING PHYSICIAN _____
HOW DID YOU HEAR OF US? _____

INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Worker's Compensation ☐ Other _____
INSURANCE COMPANY _____
INSURED / CARD HOLDER'S NAME _____ RELATIONSHIP _____
POLICY # _____ GROUP # _____ PHONE (_____) _____

SECONDARY INSURANCE INFORMATION

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Worker's Compensation ☐ Other _____
INSURANCE COMPANY _____
INSURED / CARD HOLDER'S NAME _____ RELATIONSHIP _____
POLICY # _____ GROUP # _____ PHONE (_____) _____

WORKERS' COMPENSATION INFORMATION

COMPANY NAME _____ COMPANY PHONE (_____) _____
SUPERVISOR'S NAME _____ SUPERVISOR'S PHONE (_____) _____

EMERGENCY CONTACT

SOCIAL SECURITY # _____ SEX _____
FIRST NAME _____ MIDDLE _____ HOME PHONE (_____) _____
LAST NAME _____ WORK PHONE (_____) _____

SPOUSE / GUARANTOR / RESPONSIBLE PARTY

SOCIAL SECURITY # _____ SEX _____ DATE OF BIRTH ____/____/____
RELATIONSHIP _____ DAYTIME PHONE (_____) _____
FIRST NAME _____ MIDDLE _____ EMPLOYER _____
LAST NAME _____ ADDRESS _____
ADDRESS CITY _____ _____ STATE _____ ZIP _____
CITY ST _____ ATE _____ ZIP _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

_____
SIGNATURE (Patient or Parent if Minor) DATE

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

_____
SIGNATURE D ATE

PTPC
PHYSICAL THERAPY &
PERFORMANCE CENTER
AT INDIAN ROCK
28B Indian Rock Plaza • Route 59
Montebello, N.Y. 10901-4907
(845) 368-2180 Fax (845) 368-2187

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for PTPC, Physical Therapy & Performance Center, (IRM, P.T., P.C.) to furnish medical care and treatment to_____, considered necessary and proper in diagnosing or treating his/her physical and mental conditions

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and third party payers to **PTPC, Physical Therapy & Performance Center.** (IRM, P.T., P.C.). A photocopy of this assignment is to be considered as valid as the original.

I, hereby authorize said assignee to release all information necessary, including Medical Records to secure payment.

Information Privacy: PTPC, **Physical Therapy & Performance Center** (IRM, P.T., P.C.) will use and disclose your personal health information to treat you to receive payment for the care we provide and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed **NOTICE OF PRIVACY PRACTICES** to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facility and have copies available for distribution. The undersigned acknowledges receipt of this information

Patient/Guardian:_____Date:_____

PTPC
28B INDIAN ROCK PLAZA
MONTEBELLO, NY 10901-4907
845-368-2180 FAX 845-368-2187

Notice of Privacy and Practices and Patient Acknowledgement

To Our Valued Patient:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money.
We want you to know that all of our employees, manager and therapists continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphases on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity when performing services to our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

It is our policy to listen to our employees and patients without any thought of penalization if they feel that an event in any way compromises our policy of privacy and integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

NOTICE OF PRIVACY

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The Privacy Rule provides standards for health care providers to follow when disclosing health information about the patient that is needed to carry out treatment, payment or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information. We want to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. You may request restrictions pertaining to parties you do not want PHI released to. You will be asked to authorize release of PHI to any party that is not directly connected to your treatment, payment or health care operations.

If you have any questions, comments or objections to the privacy policies on this form, please ask to speak with our HIPAA Privacy Officer. You have the right to review our entire notice of privacy policies upon request.

Please sign this form to acknowledge that you have read this notice of our privacy policies.

Patient Name: _____

Signature: _____ Date: _____

If minor, signature of parent or guardian: _____

Thank you for being one of our highly valued patients

****

For Office Use

A "good faith effort" was made to get a signature from patient. Signature was not attained due to the following:

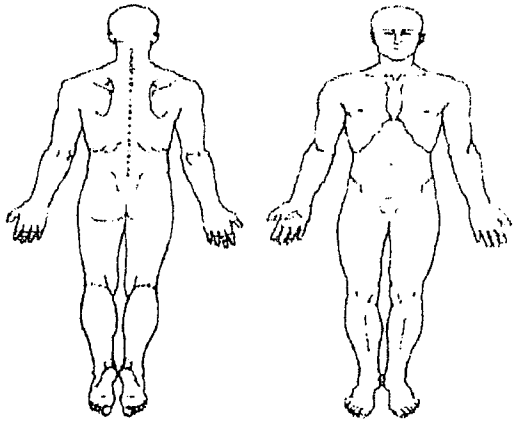
_____

_____

PATIENT PAIN EVALUATION

NAME/ DATE _____

WHERE DOES IT HURT? (Mark area(s) with an 'X')



WHEN AND HOW DID THIS EPISODE START? _____

_____

_____

Any previous similar events? No ___ Yes ___ When? _____

INTENSITY:(How bad is it? Circle the appropriate number: 0= no pain, 10= worst pain possible)

Now: 0 1 2 3 4 5 6 7 8 9 10

At worst: 0 1 2 3 4 5 6 7 8 9 10

QUALITY OF PAIN: (check all that apply) Sharp: _____ Dull: _____ Burning: _____ Ache: _____
Pressure: _____ Pins and needles: _____ Other:_____

TIMING: Worse in morning? _____ Evening? _____ Awakens at night? _____ Constant? _____
Intermittent? _____

MADE WORSE BY: Sitting? _____ While lying down? _____ Transitions? (lying or sitting to standing) _____ Turning over in bed? _____ Prolonged sitting/standing/etc? _____
Walking? _____ Running? _____

WHAT HELPS IT? _____

NAME:_____**AGE:**_____**TELEPHONE#:**_____

PLEASE DESCRIBE CHIEF PHYSICAL COMPLAINT AND HISTORY OF CONDITION:

_____

_____

HAVE YOU HAD SURGERY FOR THIS INJURY? YES NO

Type of Surgery:_____

Date of Surgery:_____

Where did your surgery take place:_____

Number of surgeries 1 2 3 4 _

CURRENT LEVEL OF PAIN (0 being no pain, 10 being requiring Emergency Room care):

0 1 2 3 4 5 6 7 8 9 10

ARE YOU CURRENTLY TAKING ANY PRESCRIPTION OR OVER THE COUNTER MEDICATIONS: YES NO

If YES, please list the medications:_____

PLEASE CHECK ANY OF THE FOLLOWING MEDICAL OR REHABILITATIVE SERVICES YOU HAVE RECEIVED FOR THIS CONDITION?

__Orthopedist
__Chiropractor
__Neurologist
__General Practitioner
__Emergency Room Care
__Injection
__Physical Therapy
__Occupational Therapy
__Massage Therapy
__Myelogram
__EMG
__Cast or Brace
__X-Rays
__CT Scan
__MRI
__NCV

Other:_____

PLEASE CHECK ANY OF THE FOLLOWING ITEMS THAT PERTAIN TO YOUR HEALTH HISTORY:

__Asthma
__Emotional or Psychological
__Headaches
__Sleeping Problems
__High Blood Pressure
__Heart Attack
__Heart Surgery
__Stroke or TIA
__Blood Clot or Emboli
__Epilepsy or Seizures
__Thyroid Trouble or Goiter
__Allergies
__Anemia
__Infectious Disease
__Numbness or Tingling
__Blurred Vision
__Ringing in Ears
__Weakness
__Weight Loss
__Night Sweats
__Hernia
__Varicose Veins
__Shortness of Breath
__Coronary Heart Disease
__Chest Pains
__Neurological Problems
__Metal Implants?
__Cancer
__Do you Smoke?
__Arthritis or Swollen Joints
__Pregnant?
__Osteoporosis

Other:_____

PLEASE LIST ANY SURGERIES YOU HAVE HAD IN THE PAST:

_____

_____

PLEASE LIST ANY OTHER RELEVANT MEDICAL HISTORY:

****EMERGENCY CONTACT:**_____ **TELEPHONE#:**_____

PATIENT/GUARDIAN SIGNATURE:_____ **DATE:**_____