Progressive Physical Therapy
28 North Country Road
Mount Sinai, NY 11766

PATIENT REGISTRATION FORM

Today's date:	Notes:

PATIENT INFORMATION (Please note all information is required)

Patient's last name:	First:	Middle:

Social Security number:	Marital status (circle one)
Birth date: / /	Single / Married / Divorced / Seperated / Widowed

Street address:	**Home Phone No.**: ( ) **Cell Phone No.:** ( )

City:	State:	Zip:	**Email:**

Occupation:	Employer:	Employer phone no.: ( )

Referred by:	❑ Friend	❑ Close to home/work	❑ Insurance Plan	❑ Dr.

Other family members seen here:

INSURANCE INFORMATION

(**Please give your insurance card to the receptionist**.)

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate **primary** insurance:				
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /		
Policy no.:	Group No.:	Co-payment: $		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Please indicate **secondary** insurance:				
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /		
Policy no.:	Group No.:	Co-payment: $		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize (Progressive Physical Therapy) or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date* *TAS 1/12*

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PATIENT QUESTIONAIRE/HISTORY

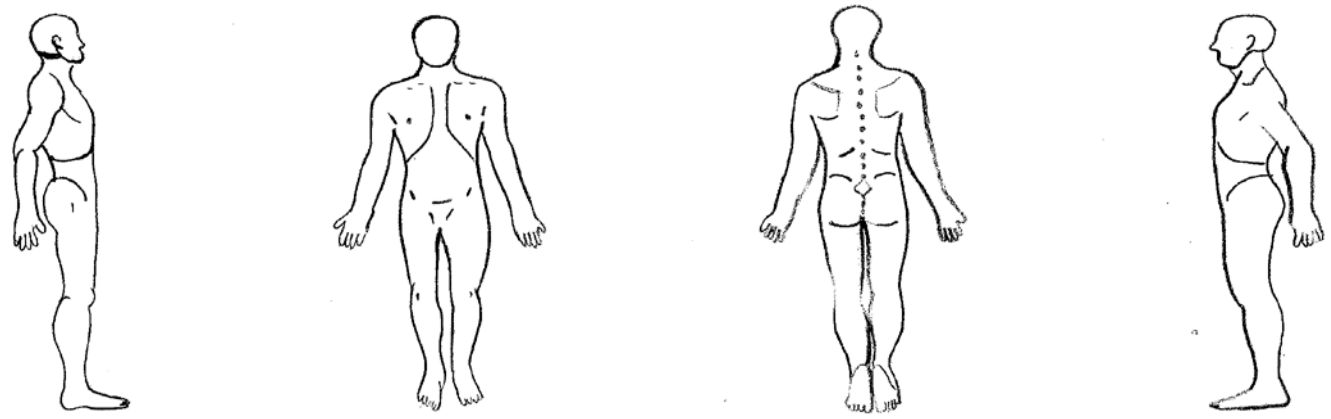
Name: _____ Date of Birth: _____
Height_____ Weight _____ Right or Left handed _____

What is your Chief Complaint?

_____
_____
_____

Rate your chief complaint in order of severity from **worst** (5) to **least** (1)
Pain____ Decreased Motion____ Swelling/edema____ Stiffness____ Loss of function_____
Indicate the nature of your pain and symptoms: ___Sharp ___Dull ___Piercing ___Shooting ___Aching ___Deep ___Superficial ___Tingling ___Numbness ___Intermittent ___Burning ___Stabbing

Where is your problem? Indicate on the body chart. **Pain** xxx: **Numbness** ooo: **Tingling** zzz:



When and how did this problem begin?

_____

What makes your symptoms/pain worse?

_____

What makes your symptoms/pain lessen?

_____

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PATIENT QUESTIONAIRE/HISTORY

Rate your pain on a visual scale (0-10) 0 no pain 10 excruciating pain: _____

Worst it has been (circle one) **A)** Past 2 to 4 weeks **B)** Past 24 hours **C)** At this moment
Are your symptoms worse in the (circle one): **A)** Morning **B)** Afternoon **C)** Evening **D)** Inconsistent
Are your symptoms (circle one): **A)** Improving **B)** Worse **C)** Stable

Has this problem affected your daily life or routine? Briefly describe in what ways

_____

_____

Have you had past similar episodes of this current problem? If yes, were you treated with;
(Circle which apply) Physical Therapy, Acupuncture, M.D. Massage Therapist, Chiropractor, Pilates, General Exercise, exercise with trainer, Self medicated (Advil), ignored it, other. Did they help to alleviate your symptoms? _____

Have you undergone any special tests for this condition? (X-rays, MRI's, ETC) If yes, do you know the results?

_____

Please answer the following questions:	**Yes**	**No**
1) Do the current problems interrupt your sleep?		
2) Do your symptoms change with coughing or sneezing?		
3) Have you had any recent changes in bowel or bladder function?		
4) Do you experience any dizziness or vertigo?		
5) Have you had any recent change in your weight or appetite?		
6) Do you have any intolerance to hot or cold?		
7) Do you have any bruising or bleeding disorders?		
8) Have you had any skin changes, such as rashes or discoloration?		
9) Have you experienced any changes in your vision, such as blurring, double vision, or decrease in your visual fields?		
10) Have you had a recent episode of nausea/vomiting?		
11) Are you pregnant?		
12) Do you have osteoporosis? Date of your last bone scan:		
13) Do you have any allergies?		
14) Have you noticed any shortness of breath or decrease in exercise tolerance?		
15) Do you use any assistive devise? (cane foot orthotics)		
16) Do you have high blood pressure?		
17) Do you have any cardiac problems?		
18) Do you have diabetes?		
19) Have you ever had cancer of any sort?		
20) Do you have a history of neck or back problems?		

Any other illness, past injuries I should be aware of?

_____

Past surgeries ___yes, ___no, give brief details:

_____

List the medications you are currently taking (over the counter/prescription):

_____

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CANCELLATIONS/NO SHOWS

The staff at Progressive Physical Therapy is committed to improving its facilities and service provided to you. As a result, it has become necessary to implement a $45 late appointment/cancellation fee for any scheduled appointments that are not cancelled within 24 hours, or for No Shows.
Your cooperation is greatly appreciated.
Thank you.

I, _____ have read and agree to the above conditions.

Signed_____ Date_____
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BILLING POLICY, RELEASE AND AUTHORIZATION

I authorize Progressive Physical Therapy to bill my insurance company directly for the covered portion of charges, and I authorize payment of benefits directly to Progressive Physical Therapy. I authorize Progressive Physical Therapy to release medical or other information necessary to process this claim. I understand that I am ultimately responsible for my physical therapy charges, and I agree to pay my deductible, my co-insurance or co-payment, and any charges not reimbursed by my insurance carrier. I understand that some insurance companies require medical or administrative pre-authorization for treatment, or have reimbursement limits on physical therapy treatments. I understand I am responsible for knowing and meeting the requirements of my insurance plan.

I, _____ have read and agree to the above conditions.

Signed_____ Date_____
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CONSENT TO LEAVE MESSAGE

I give my consent to Progressive Physical Therapy and staff to leave a message regarding scheduling, treatment, billing, or any other information necessary. (please check all that apply)

_____on an answering machine/voice mail on home phone

_____on an answering machine/voice mail on cell phone

_____with _____ relationship_____

_____ I do NOT consent to messages being left

Signed_____ Date_____

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Progressive Physical Therapy of New York, P.C.

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ❑ Medical Record from (insert date)_____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other:_____

_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) By initialing here_____ I authorize **Progressive Physical Therapy**_____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
❑ At request of individual ❑ Other:	**Cessation of Treatment**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

*** Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contact**