High Performance Physical Therapy

PATIENT INTAKE FORM

First Name: _____ Last Name: _____ Social Security #: _____

DOB: ____/____/_____ Age:_____ Gender: ☐Male ☐Female Marital Status: ☐Single ☐Widowed

Are you pregnant? ☐Yes ☐No ☐Married ☐Divorced

Address:_____ Home Phone: _____

City: _____ State: _____ Zip Code: _____ Work Phone: _____

Email Address: _____ Cell Phone: _____

Occupation: _____ Employer: _____

Emergency Contact: _____Phone: _____ Relation: _____

Insurance Information:

☐Aetna ☐BCBS ☐Cigna ☐GHI ☐Oxford ☐UHC ☐None ☐Other :_____

ID#_____

Is your condition due to an auto accident or job related injury? ☐Yes ☐No

If YES: Name of Company: _____ Policy #: _____

How did you hear about us?

☐Health Fair ☐Internet ☐Friend/ co-worker: _____☐Referred by doctor: _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Office, will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature: _____ Date: _____

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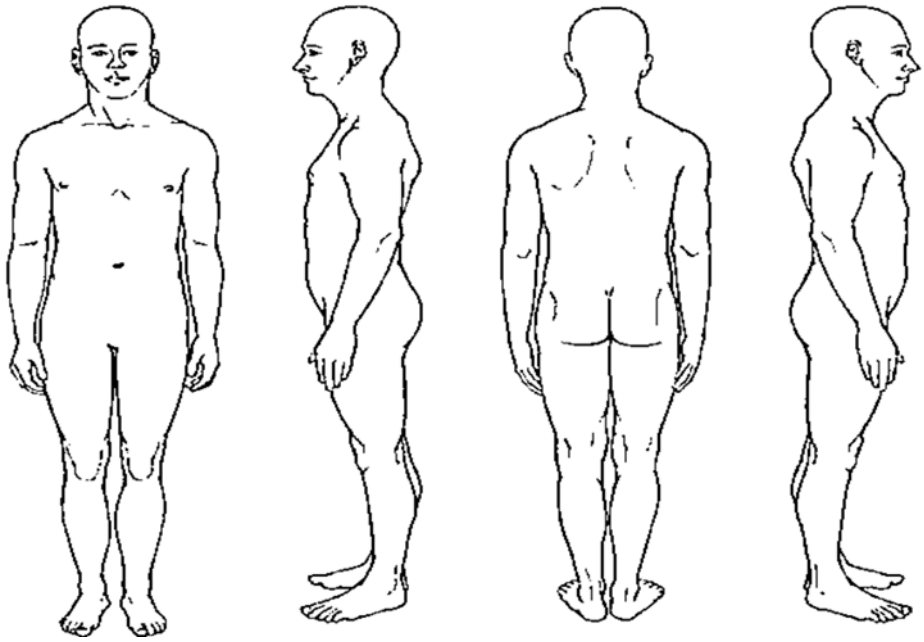
Pain Drawing

Using the descriptive symbols, draw the location of your pain on the body outlines below.
In addition, mark the level of pain you experience on the scale below.

Ache	Burning	Numbness	Pins & Needles	Stabbing	Other
^^^^	======	oooooo	. . . . .	///////	xxxx



No Pain — Please make a slash through this line as to the level of your pain — Worst Possible Pain

Medical Illness History: *(Check if you have or have had any of the following)*

	Y	N		Y	N		Y	N		Y	N
Asthma			Emphysema			Gyn. Disorders			Muscular Disease		
Diabetes			Seizures			Prostate Disease			Skin Disease		
Ulcer			Tuberculosis			Cancer			Eye Disease		
Rhuematic Disease			Syphilis			Arthritis			Hearing Defect		
Heart Disease			Abdominal Disorders			Thyroid Disease			Gall Bladder Disease		
High Blood Pressure			Kidney Disorder or Stones			Nervous Disorder			Other		

Review of Symptoms: *(Check if you have or have had any of the following in the past year)*

	Y	N		Y	N		Y	N		Y	N
Headache			Dizziness			Weight Gain/Loss			Stress		
Blurred Vision			Fainting			Palpitations			Muscle Cramps		
Hearing Loss			Vomiting			Loss of Appetite			Numb/Tingling		
Nosebleeds			Constipation			Urine Infection			Neck Pain		
Chest Pain			Diarrhea			Blood in Urine			Back Pain		
Shortness of Breath			Indigestion			Other Urine Issue			Joint Pain (list)		
Frequent Cough			Blood in Stool			Swollen Glands					
Wheezing			Abdomen Pain			Swollen Joints					
Coughing up Blood			Fatigue			Rash					

High Performance Physical Therapy
OFFICE RULES AND FINANCIAL POLICY

Our providers share your concern about the cost of medical care. We strongly believe that the best medical service is based on friendly, mutual understanding between Doctors and Patients. We therefore invite you to discuss frankly with us any questions you may have regarding our services and fees. Please free to speak with our front desk staff and one of our managers will reach out to you within 2 business days to address your concerns.

1. **Required Co-payments and or Co-insurance:** We accept all major insurances. Depending on your plan and coverage, some of our providers are either non-participating or participating. Your financial responsibility will be discussed prior to your start of care **(i.e. per visit fees, Health Savings Account, Flex Spending Accounts and such.**). We appreciate payment at the time of service and will accept, cash, checks, Visa, MasterCard, American Express and Discover. Prompt payments help keep both our costs and fees down. Payment will be collected at the time of arrival and you will receive a receipt of your payment. (printed or via email).

2. **Missed Appointments and Late Cancellation Notices:** When a patient does not show for an appointment or cancels with less than 24 hours notice, the patient will be subjected to a $50.00 no show or late cancellation fee. This fee will be taken out automatically from the credit card on file. A receipt will be emailed to the patient detailing the missed time and date of the set appointment. Note that our front desk staff will confirm all appointments.

3. **Additional Services:** High Performance Physical Therapy PLLC offers ancillary services to our patients. There might be a separate fee for adjunct services. Please check with our front desk staff for specific fees and additional services.

4. **Workers Compensation and No Fault:** We do not provide treatment for work related and no fault injury related illness/injury. If you do not disclose that your visit is a job related or no fault related case during the time of your initial visit, you are financially responsible for all charges incurred for that visit.

Credit Card Information:

Name on the card: _____ Card Number: _____

Expiration Date: _____ CVV Number: _____ Zip Code: _____

☐ Email me a receipt ☐ Print me a receipt ☐ Both

PRIVACY: We value your privacy, please note that all information gathered for this patient will only be used by High Performance Physical Therapy PLLC personnel only unless otherwise by the signatory verbally or through a written consent. Prior to any charges on this Credit/Debit Card, an email will be sent to the patient notifying them of such charge. A follow up email with the receipt with a detail breakdown of the charges will be sent.

Print Name: _____ Signature: _____

Date: _____

High Performance Physical Therapy
16 E 48th Street, 6th Floor, New York, NY 10017
212-206-6400

High Performance Physical Therapy

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for High Performance Physical Therapy PLLC to use and disclose protected health information about me to carry out treatment, payment and healthcare operations. High Performance Physical Therapy Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Rock Professional Offices reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

High Performance Physical Therapy

16 E 48th St., 6th Floor

New York, NY 10017

With this consent form, High Performance Physical Therapy may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations such as appointment reminders, insurance items and any calls pertaining to my clinical care including laboratory results, among others.

With this consent form, High Performance Physical Therapy may mail to my home or other alternative location any items that assist in carrying out treatment, payment or healthcare operations such as appointment reminder cards and patient statements as long as they are marked personal and confidential.

With this consent form, High Performance Physical Therapy may email to my home or other alternative location any time that assist the practice in carrying out treatment, payments or healthcare operations such as appointment reminders. I have the right to request that High Performance Physical Therapy restrict how it uses or discloses my PHI to carry out treatments, payments and healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to High Performance Physical Therapy use and disclosure of PHI to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent or later revoke it, High Performance Physical Therapy may decline to provide treatment to me.

_____ _____

Patient Name Date

_____

Signature of the Patient or Legal Guardian

_____

Print Name of Legal Guardian (if applicable)

High Performance Physical Therapy

Notice of Privacy Practices Acknowledgement

I understand that under the **Health Insurance Privacy & Accountability Act of 1996** (HIPPA) I have certain rights to privacy regarding my protected health insurance. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.

I acknowledge that I have reviewed your **Notice of Privacy Practice** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may obtain a current copy of the **Notice of Privacy Practices**.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do not agree that you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICIAL USE ONLY:

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

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