PhysioArts

New Patient Registration

PATIENT INFORMATION

Name:_____

Street Address:_____ Apt. #:_____

City:_____ State:_____ Zip:_____ Birth Date:_____ Age:_____

Social Security Number:_____ email:_____

Home phone:_____ work:_____ cell:_____

Occupation:_____ Referring physician:_____

Actor's Equity Association member? YES NO If yes, are you currently eligible for health benefits? YES NO

Have you been treated at PhysioArts before? YES NO If yes, when and by whom?_____

How did you first hear about PhysioArts? (Circle one):*Family/ Friend Internet Doctor Show affiliation Other:*_____

If a family or friend referred you, please write their name here so we may thank them:_____

Emergency Contact:_____ Relationship:_____

Phone: day _____evening_____

AUTHORIZATION TO RELEASE INFORMATION AND CONSENT TO TREATMENT

I hereby authorize the release of any information by telephone or in writing, including reports of diagnosis, treatment, prognosis, recommendations, benefits payable, and any other data pertinent to my treatment, by PhysioArts Physical Therapy, PC to my physician(s) as well as any organization responsible for payment of my account. I authorize my insurance company to pay medical benefits directly to PhysioArts in instances where a claim has been filed by PhysioArts on my behalf.

I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while I am a patient of PhysioArts. I understand that I play a role in this care and can question or refuse treatment at any time.

_____ _____ _____

Printed name of Patient or Guardian **Signature of Patient or Guardian** **Date**

GENERAL POLICIES

- Please notify the front desk if there are any changes to your address, phone number or insurance plan.
- Lockers are available for your use at your own risk. PhysioArts shall not be liable for the disappearance, loss, theft of, or damage to your personal property.
- New York State law allows patients to be seen for 30 days or 10 visits (whichever comes first) *without* a prescription. Any visits beyond this time period will require a prescription from a New York medical doctor, osteopath or podiatrist. Please check with your insurance company for their specific policy – some insurance companies still require prescriptions at all times for payment.
- Out of courtesy to your fellow patients, please refrain from using your cell phones in the treatment and gym areas.
- In order to ensure your safety, please do not use any equipment in the gym that you have not been instructed in and cleared to use by your physical therapist. Unsupervised use of the Pilates equipment is *not* allowed.
- Visiting children who are not being treated as patients must stay with you at all times. Children who are not being seen as patients are not allowed on any of the gym equipment.

I have read, understand and agree to all the above policies.

SIGNED:_____ **DATE:**_____

PhysioArts

Name:_____ Date:_____

CURRENT HISTORY/SYMPTOMS

Describe your current symptoms and/or activity limitations: _____

_____

Describe when and how your injury occurred: _____

_____

Have you had any diagnostic tests? □MRI □x-ray □bone scan □_____ If yes, what were the results?_____

What, if any, treatment have you had for this problem? □ physical therapy □ chiropractic □ acupuncture □ other_____

When and how frequently did/do you have this treatment?_____

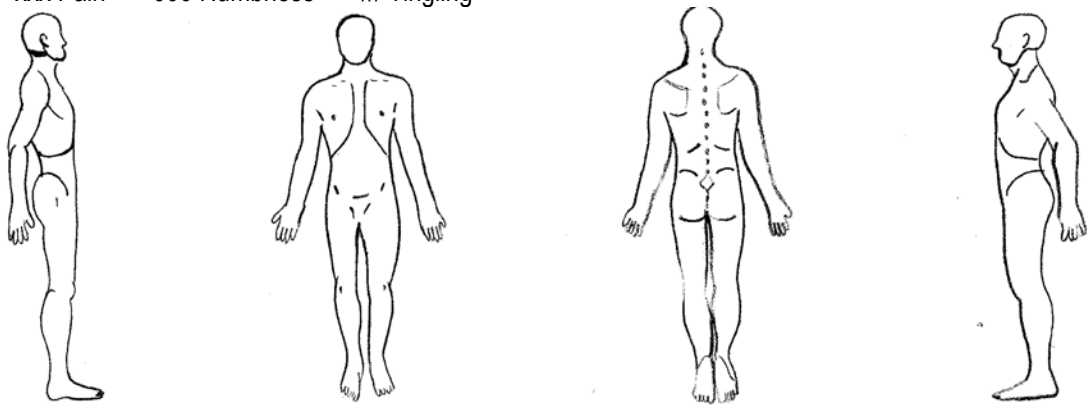
Did this treatment help? (please explain)_____

Have you had similar symptoms in the past? _____ If yes, please describe, and list the last date prior to this recent incident or flare that you had these symptoms:_____

_____

Please indicate where your pain is located and what type of pain you feel at the present time. Use the symbols below to describe your pain. Do not indicate areas of pain which are not related to your present injury or condition.

KEY: xxx Pain 000 Numbness /// Tingling



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

Worst it has been _____ Past 2-4 weeks _____ Past 24 hours _____ At this moment: _____

Indicate the nature of your pain/symptoms (check all that apply): □ sharp □ dull □ shooting □ aching □ stabbing □ burning □ stabbing □ deep □ superficial

Are your symptoms worse in the: □ morning □ afternoon □ evening □ inconsistent □ constant

Are your symptoms: □ improving □ worsening □ stable

What actions, activities or positions *aggravate* your symptoms/pain?_____

_____

What actions, activities, positions, treatments or medications *ease* your symptoms/pain? _____

_____

Special questions: *Please mark "no" if appropriate. Otherwise, please explain in the lines provided.*

No My pain is constant (24 hours/day, 7 days/week) _____

No My pain travels (eg from neck to hand or back to foot) _____

No I have a metal implant or surgical hardware in my body _____

No I have a pacemaker or other implanted device in my body _____

No I have weight-bearing restrictions given to me by my doctor _____

No I have osteoporosis or a history of fractures _____

No I have contact allergies to adhesives, latex, rubber, ice, etc. _____

No I have a heart condition and was told not to do physical activity _____

Name:_____ Date:_____

Please list your current medications (prescription and over the counter): _____

Is your injury work related? _____ Motor vehicle accident?_____

Does your occupation consist of: □ Sitting □ Standing □ Walking □ Lifting □ Heavy computer work □ Performing on a raked stage

□ Partnering □ Jumping □ Dancing in high heels □ Kneeling □ Squatting □ Wearing large costumes/headpieces

□ Other significant physicality:_____

What are your goals for physical therapy?_____

MEDICAL/ INJURY HISTORY

Have you EVER been diagnosed as having any of the following conditions?

Yes	No	Allergies	Yes	No	Circulation problems	Yes	No	Hearing loss	Yes	No	Parkinson's disease
Yes	No	Anemia	Yes	No	Diabetes	Yes	No	Heart disorders	Yes	No	Repeated infections
Yes	No	Angina	Yes	No	Digestive problems	Yes	No	High blood pressure	Yes	No	Skin diseases
Yes	No	Arthritis	Yes	No	Depression	Yes	No	Infectious diseases	Yes	No	Stroke
Yes	No	Asthma	Yes	No	Epilepsy	Yes	No	Kidney problems	Yes	No	Thyroid problems
Yes	No	Bowel/bladder problems	Yes	No	Fatigue	Yes	No	Hypoglycemia	Yes	No	Vestibular disorders
Yes	No	Cancer	Yes	No	Fever (current)	Yes	No	Lung problems	Yes	No	Ulcers
Yes	No	Chemical dependency	Yes	No	Head injury	Yes	No	Osteoporosis	Yes	No	Weight loss/gain

Please use the following lines to explain any circled above, or any medical problems not listed above:_____

_____

Please describe any injuries for which you have been treated (broken bones, dislocations, sprains, etc) including dates: _____

_____

Have you ever had surgery? _____ If yes, please list reason and dates: _____

_____

Is there any history of heart disease, diabetes or cancer in your family? □ Yes □ No If yes, please explain:_____

_____

Are you currently pregnant (or think you may be)? □ Yes □ No Past pregnancies? □ Vaginal □ Cesarean □ Other □ None

Dominant hand: □ Right □ Left

SOCIAL HISTORY

Do you smoke (#/day)? _____ Have you ever smoked? _____ When did you quit? _____ How much caffeine/day?_____

Days/week you drink alcohol? _____ What is your diet like? _____

Do you exercise?: _____If yes, how often?_____ types of exercise:_____

Have you been able to exercise despite your current injury?_____

Have you had any major life changes in the past year (move, marriage, death)? _____

DANCE/PERFORMANCE HISTORY (If applicable)

Type of dance	**# of years studied**	**age this study began**

# of years dancing professionally:_____Are you performing now? _____

Do you warm up before performing? _____ If yes, how? _____

Do you cool down after performing? _____ If yes, how? _____

PhysioArts' Patient Agreement

We appreciate your consideration in choosing PhysioArts for your rehabilitation needs, and we are committed to providing you the best care possible. In order to achieve this, we need your assistance and understanding of our scheduling, cancellation and financial policies.

SCHEDULING AND CANCELLATION POLICIES

- Please schedule your appointments in advance. Our schedule fills up quickly and we want to ensure that you get the times that you need.
- Please be timely for your appointments. We will make every effort to respect your time, and we expect that you will do the same for both your therapist and your fellow patients. In the event that you are late for an appointment, your one-on-one time with your PT will still end at the scheduled time. If you are more than 15 minutes late for an appointment, we will attempt to accommodate you later that same day. If there is no room in our schedule to do so, you will not be treated and a missed appointment fee of $40 will be applied to your account.
- PhysioArts realizes that many things arise in your busy schedules. Please give us at least 24 hours notice for cancellation or rescheduling of an appointment. Failure to comply will result in a cancellation charge of $40. If you "no-show" or "late cancel" for 3 consecutive appointments, we may remove you from the schedule.
- **All scheduling and cancellations must be done in person or over the phone with the front desk.** Emails and texts should not be used for scheduling or cancellations as these are not checked regularly. Your physical therapist cannot schedule or cancel appointments for you.
- All late cancellation, missed appointment or no show charges are due in full at your next visit. Your insurance company will not pay for any cancellation charges due to missed appointments.

PAYMENT POLICIES

- All treatment session and equipment payments are due at the time of service or via credit card on file for all patients.
- We accept Cash, Check, Debit and Credit Cards. A $25.00 service fee for the processing of any returned checks will be applied to your account.
- PhysioArts reserves the right to charge interest at the legal prevailing rate and to apply late payments or service fees for multiple payment plans as necessary to manage the collection of your account. Unresolved financial disputes for non-payment of fees for services or equipment rendered will result in discontinuation of services, referral to another provider as necessary and possible Collection Action.

PhysioArts will be happy to assist you with any questions you may have regarding your account. Please contact our Office Manager, Monday- Friday from 8am to 4pm.

I have read the above information and agree to the financial, scheduling and cancellation policies of PhysioArts.

_____ _____ _____

Printed name of Patient or Guardian **Signature of Patient or Guardian** **Date**

PhysioArts Physical Therapy
Credit Card Authorization Form

I, _____ hereby authorize PhysioArts Physical Therapy to charge my credit card for co-insurance, deductibles and any other unpaid balances over 30 days. I understand this form will not be divulged to any person not engaged in the professional use or maintenance of said files and all information will be kept confidential as required by our federal privacy policies.

☐ I would like PhysioArts to charge my credit card weekly for my treatment sessions, co-insurance, deductibles, late cancellations/no-shows and/or therapy supplies.

☐ I prefer to pay my bill each time I come in as charges accrue.

_____

Name on card (please print)

Circle one: **MASTERCARD** **VISA**

_____ _____

Card number Exp. date

_____ _____

Signature Date

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

We have a legal responsibility to focus on the privacy and security of your **Protected Healthcare Information (PHI)**. The federally mandated program, **Health Insurance Portability & Accountability Act of 1996 (HIPAA)**, has set standards for the disclosure and protection of *individually identifiable health information* and any medical records related to those individuals. This Act gives you the right of understanding and controlling how your health information is being disclosed. In compliance with HIPAA, we are notifying you of our responsibilities and how we are required to maintain privacy of your records.

There are many different purposes of disclosing your personal information. Some disclosures require written authorization or consent; others are covered under the rights of HIPAA, after having made good faith efforts to obtain your acknowledgement of receipt of this notice. We may use or disclose your PHI for the following purposes: treatment, payment, and healthcare operations.

- **For Treatment** – sharing your PHI to provide, coordinate, or manage healthcare and related services with those healthcare providers that are involved in your care. For example, discussing your case with your referring doctor or other health care providers involved in your care.
- **For Payment** – sharing your PHI to obtain reimbursement for services provided to you, confirming coverage, billing and collection with your insurance company or other company that arranges or pays for some or all of your health care ("Your Payor").
- **For Health Care Operations** – sharing your PHI to operate our practice, including but not limited to, evaluating and assessing the quality of our services and health care professionals, or conducting improvement activities. We may also share your PHI for insurance related activities, legal services, and auditors to insure our compliance with the laws set before us. For example, an internal quality assessment review.

We are permitted to use or disclose your health information without further authorization from you for the following reasons:

- Required by law
- Required for public health purposes
- To report abuse or neglect
- Required by a health oversight agency for activities authorized by law to monitor the health care system, government programs and compliance with civil rights.
- For judicial and administrative proceedings when required by law
- For law enforcement purposes when required by law to do so
- Required by coroner, medical examiner, or funeral director
- Permitted by law for organ donor purposes
- Permitted by law for research purposes
- To prevent or lessen a serious or imminent threat to the health or safety of a person or the public
- Requested by military authorities if you are a member of the armed forces
- To comply with the laws relating to Workers' Compensation or other similar programs
- Required by your employer when you receive health care services at your employer's request to evaluate the medical implications of your workplace or to evaluate whether you have a work-related illness or injury.

NY State law provides additional protection for information regarding HIV/AIDS. We will continue to follow NY State law with respect to such information.

We may contact you by mail or phone to remind you of appointments or to provide information about events at PhysioArts. Unless you instruct us otherwise, we may leave a message for you on an answering device or with any person who answers the phone at your residence.

Other uses and disclosures will be made only with your written consent and authorization. Should you wish to revoke the authorization at any time, you may do so in writing and the sharing of your PHI will be stopped immediately.

Upon a written request from you, the patient, you are granted the following list of rights regarding your protected health information:

- The right to request limits regarding the disclosure of your PHI, specifically related to the sharing with family members, close friends, or any other person identified by you. Restriction requests do not apply to the uses that we are legally required or allowed to make.
- The right to request how PHI is communicated to you by our practice. We will agree to your request if it can be provided in an efficient manner.
- The right to inspect and copy your protected health information. Copies of PHI will be charged to you.
- The right to request a correction or update your PHI. If you should request a change of your PHI, you must do so in writing including a reason for the change being made. We will consider the reason for an amendment, but we are not required to agree to a change.
- The right to request and receive a list of disclosures of any PHI made by our office.
- The right to request and receive a paper copy of this notice at any time.

We are required by law to keep this notice updated to reflect any changes regarding the manner that PHI is disclosed. You may request a revised copy of this notice should it change at any time.

To File a Complaint: If at any time you feel your privacy rights have been violated or you have a complaint about our practice, you may file a written complaint to: Attn: Office Manager, PhysioArts, 230 West 38th Street, 18th Fl, New York, NY 10018. Your complaint or concerns will not alter or affect the quality of care provided to you by PhysioArts.

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, hereby understand and acknowledge receipt of PhysioArts Physical Therapy's Notice of Privacy Practices. I understand PhysioArts has reserved a right to change its privacy practices and that any revised copies of the Notice of Privacy Practices are available to me.

I give my consent to PhysioArts to release my PHI as the Notice states. I understand that I may revoke this agreement at any time by providing a written notice of my desire to do so to PhysioArts.

If you would like someone to make appointments for you, handle payment questions and/or be allowed to discuss your care with our office, please note their name here, and check any allowed communication that applies:

_____	_____	☐ appointments	☐ payment	☐ your care
Name	Relationship	☐ by phone	☐ by email	
_____	_____	☐ appointments	☐ payment	☐ your care
Name	Relationship	☐ by phone	☐ by email	

_____ _____ _____

Signature of Patient or Guardian **Name of Patient or Guardian** **Date**

Consent for communication via e-mail with me, my referring physician and my insurance company

I hereby consent to have my physical therapist from PhysioArts communicate via email with me, my referring physician and my insurance company regarding the following aspects of my medical care: appointments, progression or status of treatment, new or changing symptoms, determination of readiness to return to work, prescriptions, authorization or billing. I understand that email is not a guaranteed confidential method of communication. I further understand that there is a risk that email communications between my physical therapists and me or my referring doctor may be intercepted by third parties or transmitted to unintended parties. I also understand that any email communications between my physical therapist and me or my referring physician regarding my diagnosis or medical care will be printed out and made a part of my medical record. **I understand that in an urgent or timely situation, or for any scheduling needs, I should call PhysioArts directly and not rely on email**.

_____ _____ _____

Signature of Patient or Guardian **Date** **Email**

For patients without a prescription for physical therapy (from a NY licensed doctor)

NOTICE OF ADVICE

New York State law now allows you to receive physical therapy treatments without a referral for a total of 10 visits or 30 days, whichever comes first. If you require further treatment beyond this, you will need to get a prescription from a physician, podiatrist, nurse practitioner or dentist in order to continue your care.

This direct access law stipulates that the physical therapist who evaluates you and creates your treatment plan must have a minimum of 3 years experience. In addition, you must be notified in writing that while the law allows this direct care, your insurance company may not cover these visits without a prescription. It is your responsibility to determine whether treatment without a prescription is a covered expense.

I understand that it is a possibility that the treatment I am receiving may not be a covered expense through my health care plan or insurer without a referral from a physician and that the treatment may be a covered expense if rendered with a referral.

I_____, have read and understand the above Notice of Advice.

Patient Signature:_____
Date:_____
Address:_____
City/State:_____

Date of initial treatment:_____
Treating Therapist:_____
PT Signature:_____
Date:_____