James Nussbaum, PT, PhD, SCS, CSCS, EMT, *Clinical Director*
150 West End Avenue #1M New York, New York 10023-5715
180 West End Avenue #1M New York, New York 10023-5715
1041 Third Avenue #204 New York, New York 10065-8114
Tel- 212.600.4781 Fax- 800.655.3780 www.prohealthptot.com
Email: phadmin@prohealthptot.com

Date: _____

Last Name: _____ First Name: _____

Middle Name: _____ Date of Birth: _____ Gender: Female____ Male____

Address: _____ Apt or P.O. Box: _____

City: _____ State: _____ Zip Code: _____ SS# _____

Home Phone: (_____) _____- _____ Work Phone: (_____) _____- _____

Cell Phone: (_____) _____- _____ Email: _____

Emergency Contact Information
Last Name: _____ First Name: _____

Phone: (_____) _____- _____ Relationship: _____

Employer Information
Name: _____

Address: _____ Suite / Office Number: _____

City: _____ State: _____ Zip Code: _____

Problem Description: _____

Primary Care Doctor: _____ Phone: (_____) _____- _____

Referring Doctor: _____Phone: (_____) _____- _____

Orthopedist: _____Phone: (_____) _____- _____

Referral Information: _____

Date of Injury: _____ / _____ / _____

Was this injury caused by an accident? Yes / No If yes, are you planning to sue? Yes / No
Is this a Motor Vehicle No-Fault case? Yes / No

Motor Vehicle Accident Injuries
If you are receiving care for injuries from a Motor Vehicle Accident, what state did the accident occur in?
_____

Is this a Worker's Compensation Case? Yes / No

If so, which part of the body was injured? _____

Primary insurance

Insurance: _____ **ID Number**: _____

Primary Holder / Subscriber Name: _____ Date of Birth: _____/ _____ / _____

Primary Holder / Subscriber Name Relationship to patient: ☐Self ☐ Spouse ☐ Parent ☐Other

Secondary Insurance

Insurance: _____ ID Number: _____

Primary Holder / Subscriber Name: _____ Date of Birth: _____/ _____ / _____

Primary Holder / Subscriber Name Relationship to patient: ☐Self ☐ Spouse ☐ Parent ☐Other

Tertiary Insurance

Insurance: _____ ID Number: _____

Primary Holder / Subscriber Name: _____ Date of Birth: _____/ _____ / _____

Primary Holder / Subscriber Name Relationship to patient: ☐Self ☐ Spouse ☐ Parent ☐Other

Have you been seen this calendar year for Physical Therapy or Occupational Therapy? Yes /No

If so, how many visits were used: _____

***** If you fail to inform us that the reason for your visit is a result of an accident and/or fail to inform us that you were previously seen by another facility for physical or occupational therapy and your insurance company denies our claims, you will be personally responsible for any balance due.**

Patient or Guardian Agreement:

☐ I authorize release of information requested by my insurance plan for payment.

☐ I understand that I am responsible for any balance due.

☐ I agree to comply with the terms and conditions are outlined in the Patient Registration form.

Signature of Patient or Guardian: _____ Date _____/ _____ / _____

Notice of Privacy Practices:

☐ I hereby acknowledge that I have been offered a copy of the Notice of Privacy Practices. (You have the right to refuse to sign this acknowledgement if you so choose.)

Signature of Patient or Guardian: _____ Date _____/ _____ / _____

Consent for the Release of Medical Information

I authorize any holder of medical or other information about me to release any information needed for this or related medical claim to ProHealth and Fitness PT OT (PH&F PT OT). I hereby agree to the use and disclosure of my personal health information for the purposed noted in PH&F PT OT's *Patient Privacy and Rights* form. In doing so, I released PH&F PT OT from all legal liability that may arise from the release of such information. I agree that a copy of this authorization may be used in place of the original.

I understand that I have the right to revoke this consent by notifying PH&F PT OT in writing at any time, except for that action which has already taken place, and no further information will be released without an additional written authorization.

Patient Signature: _____ Date: _____/ _____/ _____

Insurance and Payment Agreement

You have the right for all insurance terms and payments to be explained to you before you begin treatment. Medicare beneficiaries should be aware that Medicare's policy allows for approximately 22 visits per calendar year; however, there are some circumstances where this 'limit' can be extended, or visits can be restarted after a period of time. Many insurance companies, including Medicaid and Medicare, have a maximum number of visits that a patient can use each year. If the information shown on the initial intake paperwork is not accurate, it may result in payment denials from the insurance company and you being responsible for the visit cost. As a patient of PH&F PT OT, you are authorizing that payment of medical insurance benefits be made payable to PH&F PT OT for rehabilitation services provided that a copy of your authorization may be used in place of the original. You are also responsible for the following:

- Providing us with all your necessary insurance information
- Notifying us of any changes in your insurance policy or coverage prior to your next visit
- Notifying us of any services/treatment (nursing, physical therapy, occupational therapy, etc.) provided to you in your home by a Home Health Agency or at another facility; your visits with us will not be covered if your insurance if being used for these other services

  ** ***failure to follow the 3 requirements listed above may result in you being personally responsible for the rehabilitation services provided by us, with an amount not less than $125.00 per visit***
- Any payments and/or fees not covered by your insurance, including, but not limited to, deductibles and co- insurances
- Collection agency fees/attorney fees for unpaid balances greater than 6 months old from the initial statement date
- A **$50.00 cancellation fee (office visits) or a $75.00 cancellation fee (home visit)** paid by you for any appointments cancelled **less than 24 hours** before the scheduled time, after a one-time warning for the first occurrence.
- **I authorize PH&F PT OT to send me reminders about my appointments via PHONE or TEXT (Circle option)**

I acknowledge that I have received and consent to the policies disclosed in ProHealth and Fitness PT OT's Patient Rights and Privacy form. In addition, I have read and consent to all of the above insurance and payment policies of ProHealth and Fitness PT OT.

Patient Signature: _____ Date: _____/ _____/ _____

ProHealth and Fitness PT OT: Appointment Reminder Consent

Name: _____

Complete this form and sign below to give your permission to ProHealth and Fitness PT OT to provide automatic appointment reminder service cell phone text message.

Step One: Select <u>One</u> Option Below

☐ ProHealth may call me at my home or cell phone number to confirm my upcoming appointments to:
Home or Cell Phone: _____

☐ ProHealth may send cell phone text messages to confirm my upcoming appointments to:
Cell Phone Number: _____
I recognize that normal text messaging rates may apply.

Step Two: If you would like text messages instead of email reminders, please indicate your Cell Phone Carrier.

We cannot set your account up to send text message reminders without knowing your cell phone carrier. Please indicate your carrier below if you would like text message reminders:

☐ AllTel
☐ AT&T
☐ Boost Mobile
☐ Cingular
☐ Cricket Wireless
☐ Metrocall
☐ MetroPCS
☐ Nextel
☐ Qwest
☐ Sprint PCS
☐ T-Mobile
☐ US Cellular
☐ Verizon
☐ Virgin Mobile

_____
Signature of Patient or Guardian

_____
Date

ProHealth & Fitness PT OT: Medical History and Physical Condition

Name: _____ Date: _____

Chief Complaint: _____

1. Do you now have or have you in the past, had any of the following conditions:

Allergies	Yes ☐	No ☐	Hernia	Yes ☐	No ☐
Balance Problems	Yes ☐	No ☐	High Blood Pressure	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	HIV/AIDS	Yes ☐	No ☐
Dizzy Spells	Yes ☐	No ☐	Nervous Disorder	Yes ☐	No ☐
Headaches	Yes ☐	No ☐	Pregnancy	Yes ☐	No ☐
Hearing Problems	Yes ☐	No ☐	Seizures	Yes ☐	No ☐
Heart Attack	Yes ☐	No ☐	Sensitive to heat/cold	Yes ☐	No ☐
Heart Disease	Yes ☐	No ☐	Vision Problems	Yes ☐	No ☐

If yes on any of the above, please explain and give approximate dates of occurrences:

_____

_____

_____

2. Have you had treatment for this/these problems before? YES ☐ NO ☐
   If yes, where and when were you treated?

_____

_____

3. Have you had any surgeries? YES ☐ NO ☐
   If yes, what type of surgery did you have, who performed the surgery, and when was the surgery?

_____

_____

4. Do you currently have any metal implants? Yes ☐ No ☐
5. Do you currently have a pacemaker? Yes ☐ No ☐
6. Do you have any communicable diseases? Yes ☐ No ☐
7. Do you have cancer? Yes ☐ No ☐ If yes, please elaborate: _____

Please list ALL medications you are taking including Prescribed, Over the Counter, and Herbal.

Name: _____ Dosage: _____ Freq: _____ By Mouth? Yes ☐ No ☐

Name: _____ Dosage: _____ Freq: _____ By Mouth? Yes ☐ No ☐

Name: _____ Dosage: _____ Freq: _____ By Mouth? Yes ☐ No ☐

Name: _____ Dosage: _____ Freq: _____ By Mouth? Yes ☐ No ☐

Name: _____ Dosage: _____ Freq: _____ By Mouth? Yes ☐ No ☐

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Patient Copy: Privacy and Rights

ProHealth and Fitness PT OT (PH&F PT OT) follows the *Health Insurance Portability and Accountability Act (HIPAA)*, which establishes regulations for the use and disclosure of your Protected Health Information (PHI). Your PHI includes your personal medical records and payment history. While we use your health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care that we provide, PH&F PT OT may also:

- disclose your health information for public health purposes, audits, emergencies, and when required by law
- obtain any information necessary for your PT/OT treatment or a related medical claim from *other* holders of your PHI
- ask for your written authorization prior to disclosing/obtaining your information for any other purpose; you may revoke this authorization at any time if you wish to stop future disclosures
- use a copy of your authorization in place of the original
- make every effort to disclose only the minimum necessary information
- change our policy at any time and notify you that we have done so

As a patient of PH&F PT OT, you may:

- request a copy of your PHI or a list of any instances in which we may have disclosed your PHI for reasons other than treatment, payment, or administrative purposes
- request that we correct any inaccurate PHI
- request that we do not disclose your PHI for treatment, payment, or administrative purposes (except when specifically authorized by you, required by law, or in an emergency); we will consider these requests on a case-by-case basis, but we are not legally required to accept them
- contact our Privacy Officer, Dr. James Nussbaum, or send a written complaint to the US Department of Health and Human Services if you are concerned that your privacy rights have been violated in any way

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POLICY REMINDERS:

• If you must cancel an appointment for any reason, please call our office at least 24 hours before your scheduled time. After a one-time warning, there is a $50.00 cancellation fee for office appointments cancelled less than 24 hours in advance or a $75.00 cancellation fee for home care appointments cancelled less than 24 hours in advance.

• After a one-time warning, if you cancel more than 2 times with 24 hours advance notice, within the same month, you will be charged a $50.00 cancellation fee for office appointments or a $75.00 cancellation fee for home care appointments AND only be allowed to schedule appointments on the same day you want them if we have availability.

• If you begin to receive nursing, physical therapy, occupational therapy, or other services/treatment at another facility or in your home (through a Home Health Agency), your insurance will no longer cover your visits at ProHealth and Fitness PT OT. You must notify us immediately if you begin these services! If you do not notify us, you may be charged for the rehabilitation services provided by us, with a cost of no less than $125.00 per visit.

• You must also notify us of any changes in your insurance policy or coverage before your next visit with us.

Thank You!

If you have any questions or concerns, please do not hesitate

to contact us at 212-600-4781.