James Nussbaum, PT, PhD, SCS, CSCS, EMT, *Clinical Director*

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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

Date: _____

RETURNING PATIENTS USE ONLY:

I, _____ acknowledge that no personal information has changed since the last time I was seen in 2022. That includes, **my contact information, address, referring doctor, place of employment, primary and secondary insurance information**. If any information listed above has changed, I have requested a NEW initial intake form and completed the appropriate sections. I understand that if I do not disclose any changes, and as a result, my visits are not paid, I will be personally responsible.

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 as outlined above and on page 2.

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 _____/_____/_____

ProHealth & Fitness PT OT: Patient Initial Intake Form

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** of 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 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: _____/_____/_____

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 any and 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: _____/_____/_____

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 ☐
Circulatory Problems	YES ☐	NO ☐	HIV/AIDS	YES ☐	NO ☐
Diabetes	YES ☐	NO ☐	Kidney Problems	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 ☐

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 ☐

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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.
- If you cancel more than 3 times with 24 hours advance notice, you will 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.