Élan PHYSICAL THERAPY & WELLNESS CENTER

Movement Without Pain

PHYSICAL THERAPY & WELLNESS CENTER

New Patient Registration

Personal Information

Last Name: _____ First Name:_____ Middle initial: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Birth date: _____ Age: _____ Sex: M F Social Security Number :_____

Home phone: (_____)_____ Work phone: (_____)_____ Cell phone : (_____)_____

email address: _____ Referring Physician: _____

Contact person in case of an emergency: _____ Relationship: _____

Phone Number: Day (_____)_____ Evening: (_____)_____

How did you first hear about us? (Circle one) Family/Friend Doctor Website Other: _____

Employment Information

Employer : _____Employer Address: _____

Insurance Information

Name of Insured: _____ Social Security Number of Insured: _____

Relationship: _____ Insured Date of Birth: _____

Insurance Carrier: _____ Policy Number: _____

Authorization to Release Information, Guarantee of Account and Consent to treat:

I hereby authorize the release of any information by telephone or in writing, including reports of diagnosis, treatment, prognosis, recommendations, benefits payable, as well as any other data pertinent to my treatment by Élan Physical Therapy and Wellness Center to my physicians as well as any organization responsible for payment of my account. I also authorize the release of any information for utilization and quality review purposes.

I hereby agree to full responsibility for all expenses incurred by or on account of this patient and hereby assign Élan Physical Therapy and Wellness Center any and all insurance and settlement benefits due me to the full extent of my financial obligation to said facility. I understand I am obligated to pay the difference between any amount paid by my insurance and your fees. I understand that there may be a charge for supplies that are needed during my course of treatment that will not be covered by my insurance and for which I am financially responsible. I also understand that if I miss a scheduled appointment or if I cancel an appointment with less than 24 hours notice, I will be responsible for the full amount of the missed visit.

I hereby authorize Élan Physical Therapy and Wellness Center to render physical therapy and wellness services.

I, _____,by signing this document, acknowledge my consent
(print name)

to the above: Signed _____ Date: _____

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Élan Physical Therapy and Wellness Center Patient Agreement

Welcome to Élan Physical Therapy and Wellness Center. Thank you for choosing us to provide your care. In order to best serve you, we would appreciate if you took a moment to review and sign the following agreement. It clarifies our scheduling, billing and cancellation policies. If you have any questions please feel free to ask.

On time policy

Each scheduled appointment is approximately one hour in length. It is beneficial for you to arrive on time in order to maximize quality time with your therapist. In the event you are running late, your appointment will end at the scheduled time.

Cancellations

If you find you need to cancel an appointment, we kindly request that you do so 24 hours in advance. This allows us to offer that time to another person in need and provide you with a more convenient time. In the event you do not keep your appointment or cancel with less than 24 hours notice, you will be billed for the session. This fee is not billable to any insurance carrier. Scheduling and confirming appointments is your responsibility.

Billing

Payment in full is required at the time of service.

Insurance

In order to ensure we provide the highest quality care possible without the restrictions and limitations imposed by insurance companies, we have chosen to be an out-of-network provider. Accepting managed care contracts forces a physical therapy practice to focus on volume. Our focus is on quality and excellence. We are Medicare certified and consider Workers Compensation and No-Fault on a case by case basis.

We will be happy to assist you with any insurance concerns you may have, however, questions about your specific plan coverage should be directed to the customer service number on the back of your insurance card. You will be responsible for all non covered services and supplies. This fee is not billable to any insurance carrier.

Prescriptions

You are entitled to direct access to physical therapy. A prescription for physical therapy is not required by law. Some insurance companies, however, will only cover physical therapy with a referral from your physician, dentist, podiatrist, nurse practitioner or midwife.

Personal Property

We are not responsible for any loss of or damage to your property.

I have read, understood and agree to the above guidelines and procedures.

Signed _____ Date_____

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66 North Highland Ave • Nyack, NY 10960 • Phone: 845-512-8210

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, sharing information with your referring doctor regarding a follow-up appointment.
- For Payment – sharing your PHI to obtain reimbursement for services provided to you, confirming coverage with your insurance, billing and collection. For example, sending a bill to your insurance for payment of your visit.
- 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

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 Élan Physical Therapy & Wellness Center. 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. We will carefully consider your request but are not legally required to agree to it. If agreed upon, we will abide by the limits you have requested. 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: Practice Compliance Director, Élan Physical Therapy & Wellness Center, 66 North Highland Ave, Nyack, NY 10960. Your complaint or concerns will not alter or affect the quality of care provided to you by Élan Physical Therapy & Wellness Center.

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Patient History

Date:_____ Name:_____ Age:_____

Height:_____ Weight_____ ___Right handed ___Left handed

Present Status:

What is your chief complaint? _____

_____

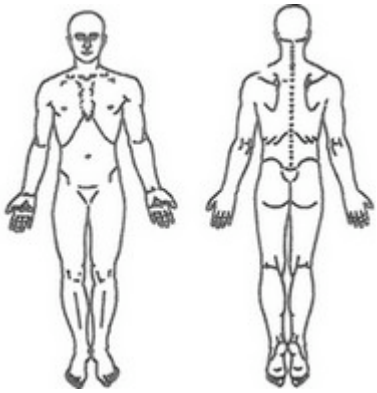
Rate your chief complaint in order of severity from 1 to 5, 1 being the least and 5 being the most severe:

___Pain ____Loss of Motion _____Swelling _____Stiffness ____Loss of Function

When did the problem begin (specify date if applicable)? _____

Please describe how your problem began: _____

Mark on the picture where you have pain or other symptoms.



Please describe the nature of your pain:

___Constant (76-100%) ___Sharp ___Dull (Pain) Ache

___Frequent (51-75%) ___Shooting ___Throbbing

___Occasional (26-50%) ___Numbness ___Burning

___Intermittent (25% or less) ___Tingling

What makes your pain or symptoms worse? _____

What eases your pain or symptoms? _____

Your symptoms are worse in: ___morning ___afternoon ___evening ___increased during the day ___same all day

Does your current problem interrupt your sleep? ___Yes ____No

Has this problem affected your daily life (job, exercise, etc)? If yes, please explain: _____

_____

_____

_____

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Since this condition began your symptoms have: ____gotten better ____not changed ____gotten worse

Have you had these symptoms in the past? ___Yes ____No If yes please describe: _____

What, if any treatment, have you had for this problem? __Physical Therapy ___Chiropractic ___Acupuncture __Other_____

Did this treatment help? ___Yes ___No Explain please:_____

Have you had any special tests (MRIs, X-rays, blood tests etc), and what were the results? _____

_____

Medical History

Do your symptoms change with coughing or sneezing?	☐ Yes	☐ No
Have you had any changes in bowel or bladder function?	☐ Yes	☐ No
Have you had any numbness in the genital region?	☐ Yes	☐ No
Have you had any problems with sexual function?	☐ Yes	☐ No
Have you had any numbness or tingling anywhere in your body?	☐ Yes	☐ No
Do you have any dizziness/light headedness?	☐ Yes	☐ No
Have you gained/lost a significant amount of weight in the last few months without trying?	☐ Yes	☐ No
Do you have an intolerance to hot or cold?	☐ Yes	☐ No
Have you had any changes in your hair/skin/nails?	☐ Yes	☐ No
Have you had any recent episodes of nausea or vomiting?	☐ Yes	☐ No
Have you had any ringing in your ears or hearing loss?	☐ Yes	☐ No
Have you had any problems with your eyes such as blurred or double vision?	☐ Yes	☐ No
Have you had any change in your sense of smell?	☐ Yes	☐ No
Have you had any change in your sense of taste?	☐ Yes	☐ No
Do you have asthma?	☐ Yes	☐ No
Do you have any shortness of breath or difficulty breathing?	☐ Yes	☐ No
Have you ever received extensive steroid therapy?	☐ Yes	☐ No
Have you ever been diagnosed with any of the following conditions?		
• Bruising or bleeding disorder	☐ Yes	☐ No
• Diabetes	☐ Yes	☐ No
• Cardiac problems/heart attack/angina	☐ Yes	☐ No
• Stroke	☐ Yes	☐ No
• High blood pressure	☐ Yes	☐ No
• High cholesterol	☐ Yes	☐ No
• Cancer	☐ Yes	☐ No
• Osteoporosis	☐ Yes	☐ No
• Rheumatoid arthritis	☐ Yes	☐ No
• Kidney problems	☐ Yes	☐ No
• Thyroid/endocrine disorders	☐ Yes	☐ No

• Hepatitis	☐ Yes	☐ No
• Rheumatic fever	☐ Yes	☐ No
• HIV/AIDS	☐ Yes	☐ No
• Seizures/epilepsy	☐ Yes	☐ No
• Depression/Anxiety	☐ Yes	☐ No
• Schizophrenia	☐ Yes	☐ No
• Drug or alcohol dependence	☐ Yes	☐ No

Are you currently pregnant? ____Yes ____No

Number of past pregnancies? _____ Delivery: Vaginal_____Cesarian_____

Please specify any complications:_____

Do you have any allergies? ___Yes ____No If yes, please specify: _____

Have you had any other conditions or illnesses?_____

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

_____

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

_____

Please list any medications you are currently taking: _____

_____

Social History

What is your current occupation? _____ Presently working? ___Yes ____No

Do you exercise/play a sport? ___Yes ____No If yes, how often? _____

Type of exercise/sport: _____

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

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

Do you smoke (#/day) ___Yes ____No

Have you ever smoked? ___Yes ____No If so, when did you quit? _____

How much caffeine/day? _____

Do you drink alcohol? ___Yes ____No If yes, how much? _____

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Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, hereby understand and acknowledge receipt of
(print name)

Élan Physical Therapy & Wellness Center's Notice of Privacy Practices. Élan Physical Therapy & Wellness Center will use or disclose my personal health information (PHI) for the purpose of carrying out treatment, payment, and health care operations. The notice provides detailed information about how my PHI may be disclosed.

I understand Élan Physical Therapy & Wellness Center 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 Élan Physical Therapy & Wellness Center 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 Élan Physical Therapy & Wellness Center.

_____ _____

Signature of Patient or Guardian Date

_____ _____

Name of Personal Representative** (if applicable) Relationship to Patient

**If you would like someone to make appointments for you or to be allowed to discuss your care with our office, please note their name here.