First Health Physical Therapy **PATIENT REGISTRATION**

I. Personal Information

Date _____ Name (Last, First) _____

Birthdate _____ Gender: ☐ Male ☐ Female

F/T Student: _____ Marital Status ☐ Single ☐ Married ☐ Other

Address _____ Apt #_____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Extension

Cell Phone _____ Email _____

Emergency Contact _____ Relationship _____

Home Phone _____ Work Phone _____ Extension _____

Referring Doctor _____ Referred By _____

II. Employment Information

Employer _____ Phone _____

Address _____ City _____ State _____ Zip _____

III. Insurance Information

Primary Insurance _____

Insurance Company _____

Phone _____

Claims Address _____

City _____State ____Zip_____

Insured Name _____

Relationship to Patient _____

Employer _____

Soc. Sec. Birthdate _____

Policy/ Certificate # _____

Group # _____

Secondary Insurance _____

Insurance Company _____

Phone _____

Claims Address _____

City _____State ____Zip_____

Insured Name _____

Relationship to Patient _____

Employer _____

Soc. Sec. Birthdate _____

Policy/ Certificate # _____

Group # _____

IV. Responsible Party

Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

V. Practice Policy & Patient Signature

Cancellations: Your appointment time is exclusively for you. It is for this reason that we request you give us **a <u>minimum</u>** of **24 hours' notice** when canceling or you will be charged for the appointment. **The cancellation fee is $125.00.**

Confidentiality: This office adheres to all rules regarding the confidentiality of patient records. Employees have access only to patient information necessary to properly perform the function of their jobs. This office will communicate with the patient's insurance companies and other health care practitioner(s) by letter, phone, or fax upon written permission from the patient. Only information necessary to process claims is released to insurance companies.

Patient Consent: 1. I have read and understand the cancellation policy.

2. I authorize the release of any medical information necessary to process all claims, and I authorize First Health Physical Therapy to communicate with my insurance companies and other health care practitioner(s) as necessary by letter, phone, or fax.

3. If assignment is accepted, I authorize and request my insurance companies to pay directly to First Health Physical Therapy benefits otherwise payable to me. **I understand that accepting assignment is a courtesy extended to me by this office and that I am financially responsible for any coinsurance, deductibles, and services that are not covered or deemed "not medically necessary" by my insurance companies.** Further, I understand that if an insurance claims **if not paid within <u>45 days</u>, I am responsible for the full amount immediately.**

4. If assignment is not accepted, I understand that I am financially responsible for all services and payment is due at each visit unless other arrangements have been made.

5. If First Health Physical Therapy is a participating provider with my insurance companies, I understand that I am subject to the terms and conditions of my insurance policy.

Signature _____ Date _____

☐ Private ☐ W.C

☐ Medicare ☐ NF

☐ Bill ins ☐ Participating _____

☐ Other _____

OFFICE USE ONLY

DX _____

Copay/ Coin _____

_____

Provider _____

Location _____

Notes _____

FIRST HEALTH PHYSICAL THERAPY

STATEMENT OF FINANCIAL RESPONSIBILITY

Patient Name: _____

First Health Physical Therapy appreciates the confidence you have shown in choosing us to provide your rehabilitation needs. The service you have elected to participate in implies a financial responsibility on your part. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. You are responsible for any copay, percentage or deductible as determined by your contract with your insurance carrier. Ultimately, you are responsible for any amount not covered by your insurance company.

Your insurance information was verified as the following:

Copay of $ _____/ per visit
Insurance will cover _____ % Patient responsibility _____ %
Deductible per year $ _____ $ _____ has been met
Out of pocket $ _____ $ _____ has been met

I have read the above information regarding my insurance policy. I certify that the information above, to the best of my knowledge, is true and accurate. I authorize my insurance carrier to pay First Health Physical Therapy directly for services provided. I agree to pay First Health Physical Therapy the entire amount of bills incurred for physical therapy services provided not covered by my insurance carrier.

Signature _____ Date: _____
(If other than patient; Relationship to patient: _____)

CONSENT OF TREATMENT & AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize First Health Physical Therapy through its appropriate personnel to perform, or have performed upon me, or the above named patient appropriate assessment and treatment procedures relating to the diagnosis stated by my referring physician.

I further authorize First Health Physical Therapy to release to the appropriate agencies, any information acquired in the course of my, or the above named patient's, examination and treatment.

Signature _____ Date: _____
(If other than patient; Relationship to patient: _____)

FIRST HEALTH PHYSICAL THERAPY

119W. 57th Street, Suite 212
New York, NY 10019
Tel: (212) 421-1740 | Fax: (212) 421-1750

NOTICE OF PRIVACY AND PRACTICES
As required by the Privacy Regulations of the Health Insurance Portability and Accountability Act (HIPAA)
EFFECTIVE DATE: APRIL 14, 2003

I have been informed of the regulations regarding the Patient Health Information Notice of Privacy and Practices by First Health Physical Therapy.

_____
Patient Name (Print)

_____
Signature of Patient/ Guardian

_____
Date

FIRST HEALTH PHYSICAL THERAPY

Medical History Form

1. Please mark the appropriate boxes that apply to your medical history:

☐ Diabetes	☐ Hypertension	☐ Cancer	☐ Heart Disease	☐ Stroke
☐ Asthma	☐ Heart Attack	☐ Emphysema	☐ Tuberculosis	☐ Angina
☐ Hepatitis	☐ Osteoarthritis	☐ Pacemaker	☐ Epilepsy	☐ Pregnant
☐ Allergies	☐ Alcohol abuse	☐ Depression	☐ Tobacco Use	☐ Drug Abuse
☐ Cardiovascular Disease		☐ Rheumatoid Arthritis		

2. Please list any other diseases or condition you have not mentioned above:

3. Please list any previous surgeries or hospitalizations:

4. Please list any medications you are currently taking. Please include the dosages:

5. Please list any recreational activities you are currently involved in:

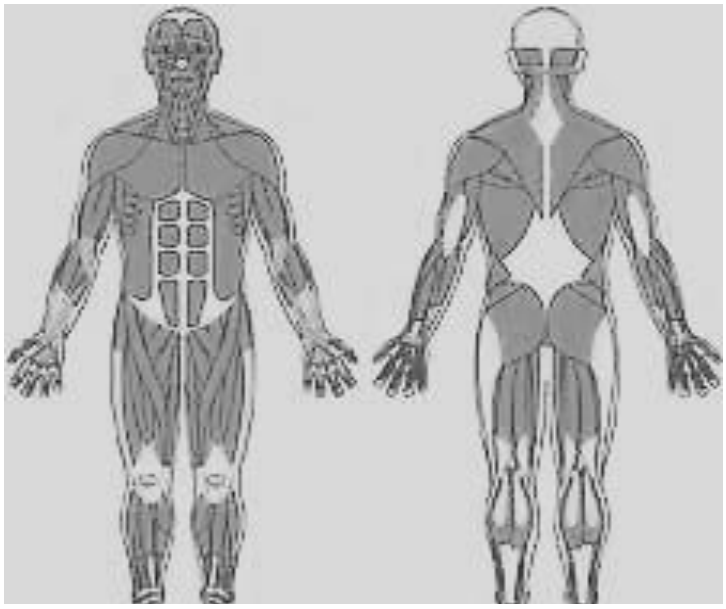
6. Please rate your pain at rest: (0 = None) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (10 = Unbearable)

7. Please rate your pain with movement: (0 = None) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (10 = Unbearable)

8. Please circle the items that best describe your symptoms:

☐	☐	☐	☐	☐	☐	☐	☐
Sharp	**Dull**	**Throbbing**	**Numbness**	**Tingling**	**Burning**	**Shooting**	**Radiating**

9. Please indicate where your pain is located:



10. Height ____ ft ____ in

11. Weight _____ lbs

12. Blood pressure: _____ systolic

_____ diastolic

NAME: _____

PATIENT NAME: _____ **DATE:** _____

Description: This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability. **Please circle the answers below that best apply.**

1. Please rate your pain level with activity: NO PAIN = 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 = VERY SEVERE PAIN

NECK DISABILITY INDEX – INITIAL VISIT

1. Pain Intensity
- ( ) I have no pain at the moment.
- ( ) The pain is very mild at the moment.
- ( ) The pain is moderate at the moment.
- ( ) The pain is fairly severe at the moment.
- ( ) The pain is very severe at the moment.
- ( ) The pain is the worse imaginable at the moment.

2. Personal Care (washing, dressing, etc)
- ( ) I can look after myself normally without extra pain.
- ( ) I can look after myself normally but it causes extra pain.
- ( ) It is painful to look after myself and I am slow and careful.
- ( ) I need some help but manage most of my personal care.
- ( ) I need help every day in most aspects of self care.
- ( ) I cannot get dressed, wash with difficulty and stay in bed

3. Lifting
- ( ) I can lift heavy weights without extra pain.
- ( ) I can lift heavy weights but it gives me extra pain.
- ( ) Pain prevents me from lifting heavy weights off the floor but I can manage if they are on a table.
- ( ) Pain prevents me from lifting heavy weights but I can manage if they are conveniently placed.
- ( ) I can lift only very light weights.
- ( ) I cannot lift or carry anything at all.

4. Headache
- ( ) I have no headaches at all.
- ( ) I have slight headaches which come infrequently.
- ( ) I have moderate headaches which come infrequently.
- ( ) I have moderate headaches which come frequently.
- ( ) I have severe headaches which come infrequently.
- ( ) I have headaches almost all the time.

5. Recreation
- ( ) I am able engage in all my recreational activities without pain.
- ( ) I am able to engage in my recreational activities with some pain.
- ( ) I am able to engage in most but not all of my usual recreational activities because of my neck pain.
- ( ) I am able to engage in a few of my usual recreational activities with some neck pain.
- ( ) I can hardly do any recreational activities because of neck pain.
- ( ) I can't do any recreational activities at all.

6. Reading
- ( ) I can read as much as I want with no pain in my neck.
- ( ) I can read as much as I want with slight neck pain.
- ( ) I can read as much as I want with moderate neck pain.
- ( ) I can't read as much as I want because of moderate neck pain.
- ( ) I can hardly read at all because of severe neck pain.
- ( ) I cannot read at all because of neck pain.

7. Work
- ( ) I can do as much as I want to.
- ( ) I can only do my usual work but no more.
- ( ) I can do most of my usual work but no more.
- ( ) I cannot do my usual work.
- ( ) I can hardly do any usual work at all.
- ( ) I can't do any work at all.

8. Sleeping
- ( ) Pain does not prevent me from sleeping well.
- ( ) My sleep is slightly disturbed (<1 hr sleep loss).
- ( ) My sleep is mildly disturbed (1-2 hr sleep loss).
- ( ) My sleep is moderately disturbed (2-3 hr sleep loss).
- ( ) My sleep is greatly disturbed (3-4 hr sleep loss).
- ( ) My sleep is completely disturbed (5-7 hr sleep loss).

9. Concentration
- ( ) I can concentrate fully when I want with no difficulty.
- ( ) I can concentrate fully when I want with slight difficulty.
- ( ) I have a fair degree of difficulty concentrating when I want.
- ( ) I have a lot of difficulty concentrating when I want.
- ( ) I have great difficulty concentrating when I want.
- ( ) I cannot concentrate at all.

10. Driving
- ( ) I can drive my car without neck pain.
- ( ) I can drive my car as long as I want with slight neck pain.
- ( ) I can drive my car as long as I want with moderate neck pain.
- ( ) I can't drive my car as long as I want because of moderate pain.
- ( ) I can hardly drive my car at all because of severe neck pain.
- ( ) I can't drive my car at all.

Therapist Use Only

Comorbidities:
- ☐Cancer
- ☐Diabetes
- ☐Heart Condition
- ☐High Blood Pressure
- ☐Multiple Treatment Areas
- ☐Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI)
- ☐Obesity
- ☐Surgery for this Problem
- ☐Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)

ICD9 Code: