



New Patient Registration  
**Personal Information**

Last Name: \_\_\_\_\_  
First Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home #: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_  
Cell #: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_  
email: \_\_\_\_\_  
SS #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Sex: F M Date of Birth: \_\_\_\_\_  
Referring Physician: \_\_\_\_\_

**Employment Information**

Employer: \_\_\_\_\_  
Employer Address: \_\_\_\_\_  
Responsible Party: \_\_\_\_\_  
Address: \_\_\_\_\_

**Insurance Information**

Name of Insured: \_\_\_\_\_  
SS # of Insured: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Insured's Date of Birth: \_\_\_\_\_  
Insurance Carrier: \_\_\_\_\_  
Policy #: \_\_\_\_\_

Contact person in case of emergency: \_\_\_\_\_  
Phone: ( ) \_\_\_\_\_

**I authorize all payment of medical benefits directly to Thrive Integrated Physical Therapy, PC for all services rendered. I agree to be responsible for deductible and co-payment fees.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please Note: SCHEDULED APPOINTMENTS MUST BE CANCELLED AT LEAST 24 HOURS IN ADVANCE OR A \$100 LATE CANCEL CHARGE WILL BE ASSESSED. SIMILARLY, IF YOU MISS A SCHEDULED APPOINTMENT, A \$100 FEE WILL BE ASSESSED. THIS FEE IS NOT BILLABLE TO YOUR INSURANCE.**

I have read and understand this policy.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Physical Therapy Patient Agreement

Thank you for choosing Thrive Integrated Physical Therapy. Please read and sign the following agreement; it explains our billing, scheduling and cancellation policies. If you have any questions, we will be glad to answer them.

All patients of Thrive Integrated Physical Therapy must have a valid, written prescription from a medical doctor, osteopath or podiatrist. Patients are responsible for scheduling and confirming appointments with the front desk.

Payment of all fees is expected at time of service or via credit card on file. We will assist you in submitting claims to your insurance carrier. However, you are still responsible for any deductible, co-insurance/co-payments or claim denied by your insurance carrier. Should your account go into arrears, all attorney fees will be charged in addition to your outstanding balance.

I hereby authorize Thrive Integrated Physical Therapy, PC, having treated me, to release to government agencies, insurance carriers, and all others who are financially liable for my care, all information needed to substantiate payments for care and to permit representative thereof to examine and make copies of all records related to such care and treatment. I understand that if, at any point, my insurance coverage changes, I am to notify the staff prior to my next visit. Failure to do so will result in my being responsible for the full amount of services.

A scheduled appointment must be cancelled at least 24 hours in advance or a \$100 late cancel fee will be assessed. Similarly, if you do not show up for a scheduled appointment, a \$100 fee will be assessed. **This fee is not billable to any insurance carrier.** We reserve the right to remove you from the treatment schedule if you cancel without 24 hours notice or if you do not show up for your appointments **three consecutive times.**

Lockers are available for your use at your own risk. Thrive shall not be liable for the disappearance, loss, theft of, or damage to your personal property: this would include money, negotiable securities, furs or jewelry.

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

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Signature of patient or authorized representative



## Credit Card on File Agreement

In order to expedite your billing through your commercial insurance carrier, we require that you make your co-payments on a per visit basis. Payment can be made by cash, check or credit card.

All patients are required to keep personal credit card information on file.

If you would like, Thrive will bill your account twice monthly for co-payments for the 1<sup>st</sup> through 15<sup>th</sup>, and again for the 16<sup>th</sup> through 31<sup>st</sup>. A paid invoice and copy of the receipt will be sent to you for your records.

In addition, any insurance policy deductibles will be charged against your credit card once we have been sent proper notification by your major medical insurance carrier. A paid invoice and copy of the receipt will be sent to you for your records.

If you attend Thrive on an out of network basis, we require that you send us insurance payment checks endorsed to Thrive, as well as the attached explanation of benefits ("EOBs") upon receipt. If we do not receive payment from you for services within two weeks of your having received payment from your insurer, we will bill your credit card for the full balance of the visit.

\_\_\_\_\_

Name (please print)

\_\_\_\_\_

Date

Credit Card: Please circle one

**VISA**

**MASTERCARD**

**AMEX**

**DISCOVER**

Card #: \_\_\_\_\_

Exp. Date: \_\_\_\_\_

Signature on file: \_\_\_\_\_

Security Code: \_\_\_\_\_

Thank you for your attention in this matter.

## Physical Therapy Patient History

Date:	Last Name:	First Name:	Age:	<input type="checkbox"/> Right-handed
				<input type="checkbox"/> Left-handed

**Present Status**

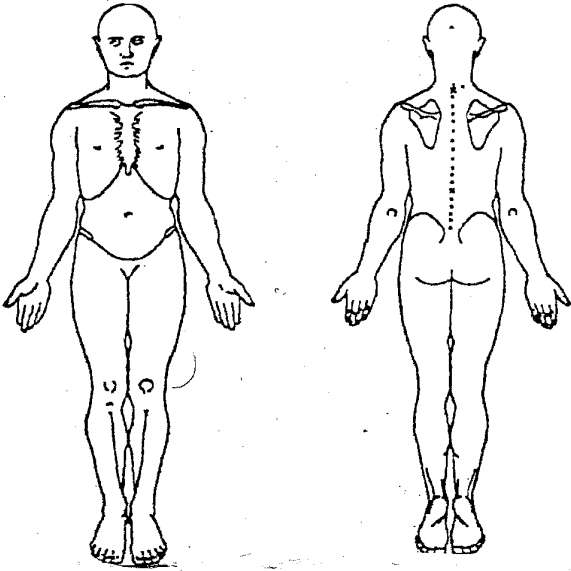
What is your chief complaint

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

\_\_\_ Pain      \_\_\_ Loss of Motion      \_\_\_ Swelling      \_\_\_ Stiffness      \_\_\_ Loss of Function

When the did the problem begin (specify date if applicable):

How did the problem begin?

	<p style="text-align: center;">Where is the problem?</p> <p>Indicate where your symptoms are on the diagram to the left with the symbol indicating the type of pain or symptoms you are having.</p> <p>+ = Numbness/tingling</p> <p># = Pain</p> <p>&lt;&gt; = Other _____</p>
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What in particular makes your pain or symptoms worse?

What , if anything, eases your pain or symptoms

How are your symptoms in the morning?

How are your symptoms in the afternoon?

How are your symptoms at night (does your current problem interrupt your sleep?)

Has this problems affected your daily life (job, exercise, etc.,)?

Are your symptoms  Improving     Stable     Worse

Have you had previous similar occurrences of these symptoms?  Yes     No

If yes, please describe:

Are there any other medical conditions that we should be aware of?

**Present Status (cont'd)**

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 test (MRIs, x-rays, etc.,) and what were the results?

\_\_\_\_\_

**Medical History**

Did your symptoms change with coughing or sneezing?.....  yes  no

Have you had any changes in bowel or bladder function or anesthesia in this area?.....  yes  no

Do you experience any dizziness or vertigo?.....  yes  no

Do you have bilateral tingling in hands and/or feet?.....  yes  no

Do you have any gait disturbance?.....  yes  no

Have you had any recent change in your weight or appetite?.....  yes  no

Do you have an intolerance to hot or cold?.....  yes  no

Do you have any bruising or bleeding disorders?.....  yes  no

Have you had any skin change, such as rash or discoloration?.....  yes  no

Have you any recent episodes of nausea or vomiting?.....  yes  no

Have you experienced any recent change in vision, such as blurred or double vision?.....  yes  no

Have you noticed any shortness of breath or change in exercise tolerance?.....  yes  no

Are you pregnant?.....  yes  no

Have you received extensive steroid therapy?.....  yes  no

Do you have any allergies?.....  yes  no

If yes, please specify \_\_\_\_\_

Do you have any cardiac problems?.....  yes  no

Do you have high blood pressure?.....  yes  no

Do you have diabetes?.....  yes  no

Do you have a history of cancer?.....  yes  no

Do you have osteoporosis?.....  yes  no

Do you have asthma?.....  yes  no

\*\*Are there any other conditions or illnesses we should be away of?.....  yes  no

If yes, please specify: \_\_\_\_\_

List any past surgeries you have had:

\_\_\_\_\_

List all medications you are presently taking:

\_\_\_\_\_

**Social history**

What is your current occupation? \_\_\_\_\_ Presently working?  yes  no

What is your activity level  Sedentary  Light  Heavy  Very Heavy

What type of sports do you participate I, if any?

Do you use tobacco?  yes  no Do you drink alcohol?  yes  no

**Family History**

Has any member of your family had high blood pressure, diabetes, cardiac problems or cancer

If yes, please explain:

\_\_\_\_\_

Patient 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.**

**Effective January 1, 2004**

The privacy of your medical information is important to us. You may be aware that the US government regulators established a privacy rule through the Health Insurance Portability and Accountability Act ("HIPAA"), governing protected health information. This notice tells you about how it may be used, and about certain rights that you have.

Thrive Integrated Physical Therapy, PC is in charge of privacy matters at our facility. You can contact either Rena Amitay or Tamar Amitay with any questions of concerns you might have.

**Use and disclosure of protected information.**

Federal law provides that we may use your medical information (protected health information) for treatment of you, without further specific notice to you, or written authorization by you; for example, we may send your referring physician a copy of your initial evaluation or a periodic progress report to let them know how your care is progressing.

Federal law provides that we may use your medical information to obtain payment for our services without further specific notice to you, or written authorization by you; for example, most insurance carriers require a copy of your documentation to pre-certify care, extend care and review specific claims for payment.

Federal law provides that we may use your medical information for healthcare operations without further notice to you, or written authorization by you; for example, our accountants may see you name, dates of treatment and procedure codes during audits of our records.

We may use or disclose your medical information without further notice to you or authorization by you where:

- required by law
- required for public health purposes;
- required by law to report child abuse;
- where required by a health oversight agency for activities authorized by law, such as the Department of Health, Office of Professional Discipline or Office of Professional Medical Conduct.
- required by law in judicial or administrative proceedings;
- required by law enforcement purposes by a law enforcement official
- required by a coroner or medical examiner
- permitted by law for organ donor purposes
- permitted by law to a funeral director

- permitted by law to avert a serious threat to health or safety
- permitted by law and required by military authorities if you are member of the US Armed Forces
- permitted by law for research purposes.

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 at your residence to remind you of appointment or to provide information about treatment alternatives. 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.

You can make reasonable requests, in writing, for us to use alternative methods of communicating with you in a confidential manner. Space is provided on this form below.

Other uses of disclosure of your medical information will be made only with your written authorization. You have the right to revoke any written authorization that you give.

### **Rights that you have**

You have the right to request restrictions on certain of the uses or disclosures described above. Except as stated below, we are not required to agree to such restrictions.

You have the right to inspect and obtain copies of your medical information (a reasonable fee will be charged).

You have the right to request amendments to your medical information. Such requests must be in writing, and must state the reasons for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosures we make of our medical information, except for: disclosures we make to you or carry out treatment, payment or health care operations or as requested by your written authorization, or a permitted or required under 45 CFR 164.502, or for emergency or notification purposes, or for national security or intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law (or for research or public health purposes after being de-identified or limited to remove personally identifiable information) or disclosures made before January 1, 2004.

**Obligations that we have**

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices.

We are required to abide by the terms of this notice as long as it is currently in effect.

We reserve the right to revise this notice and to make a new notice effective for all protected health information we maintain. Any revised notice will be posted in our facility and copies will be available there.

if you want to complain about violations of your privacy rights, you have the right to file a complaint with the Secretary of the Department of Health and Human Services of the United States. You may also file a complaint with us directly. Complaints should be directed to

Rena Amitay  
Thrive Integrated Physical Therapy, PC  
611 Broadway, Suite 503  
New York, NY 10012  
(212) 254-7750

No retaliatory action will be taken against you for any complaint that you make.

I have received a paper copy of this notice

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

I make the following special request(s) for confidential communications:

Signature: \_\_\_\_\_

Date: \_\_\_\_\_