

NEW PATIENT REGISTRATION

Personal Information

First Name: _____ Last Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home # : _____ Work #: _____
Cell # : _____ Fax #: _____
Date of Birth: _____ SS # : _____
Email: _____
Emergency Contact: _____ Phone #: _____

Insurance Information

Insurance Carrier: _____
Policy #: _____ Group #: _____
Policy Holder: _____ Relationship: Self Guardian Spouse/Partner
Employer: _____

Referral Information

How did you hear about Thrive Integrated Physical Therapy? (please circle)
Doctor Google Yelp Bing Facebook Advertisement
Friend: _____ Other: _____
Referring Physician: _____

Appointment Reminders (Note: we will notify you when this service becomes available)

As a courtesy to our patients we offer appointment reminders via email or text. Please indicate your preference by adding your contact information in the appropriate field below:

Email: _____ Text: _____

Note: Please keep in mind that although we offer this service, it is your responsibility to keep track of your appointments. If you have a question about the date or time of an upcoming appointment, please call the office.

Email Consent

New regulations require that anyone using email to communicate with healthcare providers understand and agree to certain conditions and limitations.

1. The transmission of patient information via email has a number of risks including but not limited to: email is not secure; email can be intercepted, misaddressed, altered, forwarded, or used without authorization or detection; email may be circulated, forwarded and stored in paper and electronic files even after the sender or recipient has deleted his or her copy.

2. The Practice will use all reasonable means to protect the security of the email, however we cannot guarantee email confidentiality. The Practice is not liable for improper disclosures unless they are caused by the Practice's intentional misconduct.

I have read and understand the email disclaimer and give consent to Thrive Integrated Physical Therapy, PC to correspond with me via email, if necessary.

Patient 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.
- In order to achieve maximum therapeutic benefit from physical therapy you must attend regularly scheduled appointments and adhere to the home exercise program assigned to you. If you have difficulty with your home exercises, please discuss this with your therapist.
- Patients are responsible for scheduling and confirming appointments with the front desk. If you can not make a scheduled appointment it 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 3 consecutive times.
- 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(s) denied by your insurance carrier. Should your account go into arrears, all attorney fees will be charged in addition to your outstanding balance.
- 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 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.

I have read, understand and agree to all the above policies and procedures and voluntarily consent to physical therapy treatment.

Patient Signature

Date

PATIENT HISTORY

Name: _____

Age: _____ Right-handed Left-handed

What is your chief complaint: _____

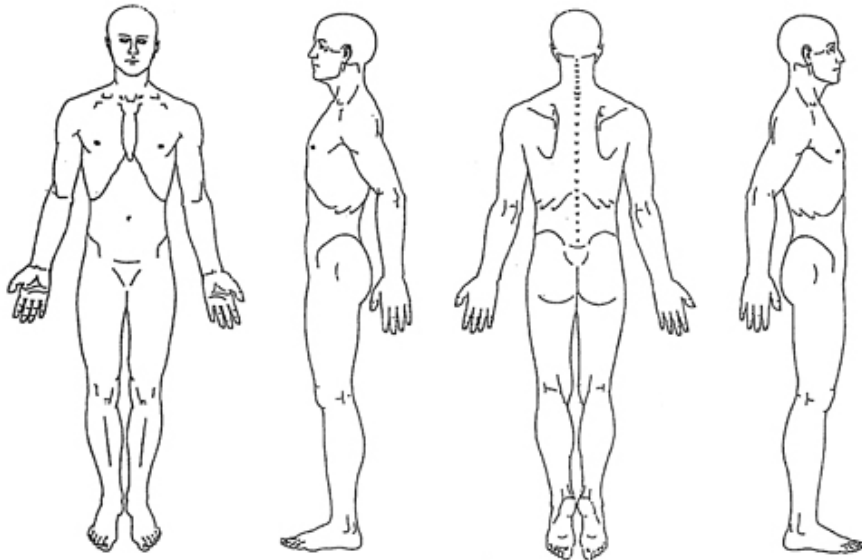
Rate your chief complaint in order of severity from 1 to 5, with 1 as the least and 5 being the most severe:

___ Pain ___ Loss of Motion ___ Swelling ___ Stiffness ___ Loss of Function

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

How did the problem begin: _____

Have you had any special tests (MRIs, x-rays, etc..) and if so, what were the results: _____



Indicate where your symptoms are on the diagram to the left.

Use the symbols below to indicate the type of symptoms you are experiencing.

- + Numbness/Tingling
- # Pain
- > Other _____

Circle a number from 0-10 to indicate the severity of your pain:

no pain = 0 1 2 3 4 5 6 7 8 9 10 = unbearable pain

What makes your pain/symptoms worse: _____

What, if anything, eases your pain/symptoms : _____

Are your symptoms worse in: The morning The afternoon The evening

Details: _____

Does your current problem disrupt your sleep: Yes No Occasionally

Since the initial onset, are your symptoms: Improving Stable Worse

Have you had similar occurrences of these symptoms in the past: Yes No

If yes, please describe: _____

Allergies (please specify): _____

List current medications: _____

List any past surgeries: _____

Do you have a pacemaker: Yes No Are you pregnant: Yes No

Are there any other medical conditions or illnesses we should be aware of: Yes No

If yes, please specify: _____

Have you had anesthesia in the area where your symptoms occur: Yes No

_____ check all boxes that apply _____

With your current complaint do you experience:

- | | |
|---|---|
| <input type="checkbox"/> Changes in bowel or bladder function | <input type="checkbox"/> Dizziness or Vertigo |
| <input type="checkbox"/> Tingling in hands and/or feet | <input type="checkbox"/> Nausea or Vomiting |
| <input type="checkbox"/> Changes in weight or appetite | <input type="checkbox"/> Fever, Chills or Sweats |
| <input type="checkbox"/> Intolerance to hot or cold | <input type="checkbox"/> Bruising or bleeding disorders |
| <input type="checkbox"/> Skin change (rash, discoloration, etc.) | <input type="checkbox"/> Problems with coughing or sneezing |
| <input type="checkbox"/> Changes in vision (blurred, double vision) | <input type="checkbox"/> Gait disturbance |
| <input type="checkbox"/> Muscular weakness | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Changes in exercise tolerance | <input type="checkbox"/> Headaches |

_____ check all boxes that apply _____

Have you or an immediate family member ever been told that you have:

- | | | |
|---------------------|------------------------------|---------------------------------|
| Cancer | <input type="checkbox"/> You | <input type="checkbox"/> Family |
| Diabetes | <input type="checkbox"/> You | <input type="checkbox"/> Family |
| Asthma | <input type="checkbox"/> You | <input type="checkbox"/> Family |
| Osteoporosis | <input type="checkbox"/> You | <input type="checkbox"/> Family |
| High Blood Pressure | <input type="checkbox"/> You | <input type="checkbox"/> Family |
| Heart Disease | <input type="checkbox"/> You | <input type="checkbox"/> Family |

For your current condition, have you received treatment from:

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> Orthopedist | <input type="checkbox"/> Physical Therapist |
| <input type="checkbox"/> Osteopath | <input type="checkbox"/> Acupuncturist |
| <input type="checkbox"/> Physiatrist | <input type="checkbox"/> Massage Therapist |
| <input type="checkbox"/> Neurosurgeon | <input type="checkbox"/> Chiropractor |
| <input type="checkbox"/> Podiatrist | <input type="checkbox"/> Internist |
| <input type="checkbox"/> OBGYN | <input type="checkbox"/> Other _____ |

What is your current occupation: _____ Presently working: Yes No

What is your activity level: Sedentary Light Active Very Active

What type of athletic activities do you participate in: _____

Do you drink alcohol: Yes No Occasionally

Do you use tobacco: Yes No Occasionally

Patient Signature: _____ **Date:** _____

PATIENT PAYMENT 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.

If you attend Thrive on an out of network basis, we require that you send us insurance payment checks endorsed to Thrive PT, 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.

If you would like, Thrive will bill your account twice monthly for co-payments for the 1st through 15th, and again for the 16th through 31st. 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.

CREDIT CARD ON FILE

Note: All patients who bill through a commercial insurance carrier are *required* to keep a credit card on file. Please indicate below how you prefer to pay for your therapy sessions:

- I would like Thrive to charge my credit card twice monthly for my co-payments, deductible and other authorized purchases (ie. therapy supplies).
- I will leave my credit card on file, but prefer to pay my bill each time I come in.

Name on Card (please print)

Circle one: **AMEX** **MASTERCARD** **VISA** **DISCOVER**

Card Number

Sec. Code

Exp. Date

Signature

Date

2012 MEDICARE GUIDELINES

We realize that negotiating the Medicare system can seem daunting. In an effort to provide you with optimal service we would like to make you aware of Medicare's rules for outpatient physical therapy.

- The annual limit for outpatient physical therapy and SLP therapy (speech language pathology) for 2012 is \$1880, which we **estimate** to be approximately 13 visits at Thrive. This includes one evaluation appointment.
- Medicare claims for physical therapy **require** a prescription/referral from a physician. The prescription is good for 30 days.
- Medicare requires your physician to certify a Plan of Care. Your therapist will send your physician an Evaluation Report including a Plan of Care for him/her to sign and return to Thrive.
- After 30 days or 10 visits, your therapist will send a progress report to your physician. After 30 days you will also be required to obtain an updated prescription from your physician for continued treatment.

We appreciate your assistance in helping us to meet the aforementioned guidelines. Compliance with the Medicare guidelines will ensure that you are properly reimbursed for our services.

If you have any questions regarding the course of your care please bring it to the attention of your therapist. If you have questions about the expiration of your prescription or visit allowance, please ask the front desk staff.

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 Tamar Amitay with any questions or 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

Tamar Amitay, MSPT
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: _____