INNOVATIVE PHYSICAL THERAPY OF LONG ISLAND, PC
PATIENT REGISTRATION FORM

PATIENT INFORMATION:

Last Name: _____ **First Name:** _____

Address: _____

City/State/Zip: _____

Date of Birth: _____ **Sex: M F Social Security#:** _____

Home Phone: _____ **Cell Phone:** _____

How do you prefer we contact you? HOME CELL

Do you live alone? YES NO if No who do you live with? _____

Email _____

Address: _____

Emergency Contact _____ **Phone Number**_____

Employer_____ **Occupation:** _____

Business Address & Phone: _____

Responsible Party if Patient is a Minor: _____

PRIMARY INSURANCE:

Insurance Company: _____

Policy Number: _____ **Group Number** _____

Insurance Address: _____

Policy Holder _____ **Policy Holder SSN:** _____

Policy Holder Address: _____

Policy Holder Employer: _____ **Policy Holder Date of Birth:** _____

Relationship to Insured: _____

SECONDARY INSURANCE:

Insurance Company: _____

Policy Number: _____ **Group Number** _____

Insurance Address: _____

Policy Holder _____ **Policy Holder SSN:** _____

Policy Holder Address: _____

Policy Holder Employer: _____ **Policy Holder Date of Birth:** _____

Relationship to Insured: _____

Date of injury/onset _____ **Have you ever had these symptoms before?** YES NO

Have you had Physical Therapy before? YES NO If yes, how many visits this year? _____

Are you currently working? YES NO Did you miss work because of injury? YES NO

Last Date Worked Due to this Injury: _____

Date Returned to Work After Injury: _____

INNOVATIVE PHYSICAL THERAPY OF LONG ISLAND, PC

Are you currently working? YES NO Did you miss work because of injury? YES NO
Last Date Worked Due to this Injury: _____
Date Returned to Work After Injury: _____

WORKER'S COMPENSATION _____
Is this visit covered by Worker's Comp? YES NO If NO, skip this section
Date of Accident: _____
(WC) Employers Name: _____
(WC) Employer Address: _____
Employer Phone Number: _____
Insurance Carrier: _____
Insurance Carrier Address: _____
Claims Adjuster: _____ Claims Adjuster Phone#: _____
WCB #: _____ Carrier Case#: _____

NO FAULT:

Is this visit covered by No Fault? YES NO If NO, skip this section
Policy Holder: _____ Policy #: _____
Date of Accident: _____ Claim#: _____
Insurance Carrier: _____
Insurance Carrier Address: _____
Claims Adjuster: _____ Claims Adjuster Phone #: _____

Is an attorney involved in this Case? YES NO

Attorney Name: _____
Phone Number: _____

INNOVATIVE PHYSICAL THERAPY OF LONG ISLAND, PC

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for *Innovative Physical Therapy of Long Island, PC* to furnish medical care and treatment to _____ considered necessary and proper in diagnosis or treating his/her physical and mental condition.

SIGNATURE: _____ DATE: _____

AUTHORIZATION FOR RELEASE OF INFORMATION BY INNOVATIVE PHYSICAL THERAPY OF LONG ISLAND,PC

I hereby authorize and direct the above named clinical practice, having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and t6 permit representatives thereof to examine and make copies of all records relating to such treatment Upon my request for release of my medical records, I hereby authorize Innovative *Physical Therapy of Long Island, PC* to furnish all records and results to the parties I specify.

SIGNATURE: _____ DATE: _____

ASSIGNMENT OF BENEFITS

I hereby assign, transfer and set over to the above named clinical practice sufficient monies and/or benefits to which I may be entitled from government agencies, insurance earners or others who are financially liable for my medical costs of the care arid treatment rendered to myself or my dependent in said practice. I understand I am responsible for any services not covered by my insurance. I accept responsibility for payment of my account

SIGNATURE: _____ DATE: _____

NOTICE OF PRN ACY PRACTICES

As a result of the Health Insurance Portability and Accountability Act (HIPAA), enforced by the US Department of Health and Human Services office of CMI Rights, we are not permitted to release patient information except as stated in the Notice of Privacy Practices On this date I received and reviewed *Innovative Physical Therapy of Long Island, PC* Notice of Privacy Practices, which describes how my medical information may be used and disclosed and explains how I can get access to this information. I had an opportunity to raise questions regarding this policy and all of my questions have been answered. This authorization will remain effective until such time as I notify Innovative Physical Therapy of Long Island, PC in writing, by certified mail, of requested changes.

SIGNATURE: _____ DATE: _____

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM
(FOR ACCIDENTS OF OCCURING ON AND AFTER 3/1/02)

I, _____, ("Assigner") hereby assign to _____,
(Print patient name) (Print health care provider name)
("Assignee") all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the N0-Fault-status) of the insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the assignor and shall not pursue payment directly from the assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____, notwithstanding
(Print accident date)
any other agreement to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH THE INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR THE COMMERCIAL INSURANCE OR A STATEMENT OF CLAM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OF CLAM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER T MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTURE OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO BE EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

_____ _____
(Print name of Patient) (Signature of Patient)

_____ _____
(Date of signature)

_____
(Address of Patient)

_____ _____
(Print name of Provider) (Signature of Patient)

_____ _____
(Date of signature)

_____
(Address of Patient)

INNOVATIVE PHYSICAL THERAPY OF LONG ISLAND, PC

PATIENT MEDICAL HISTORY QUESTIONNAIRE

Briefly describe why you are here today:

_____

_____

_____

Have you had surgery for this injury? YES NO

Type of Surgery _____ Date. _____

Took Place at _____

Pain (please draw a vertical line where you would rate your pain intensity):

0----------5----------10

No Pain Maximum Pain

My pain can be described as (please circle all that apply):

Constant Intermittent Sharp Dull Aching Stabbing Numbness Pins/Needles

Does your pain wake you up at night? YES NO

If yes, are you able to fall back asleep?

ALWAYS MOST OF THE TIME SOMETIMES RARELY

What makes your pain better? _____

What makes your pain worse? _____

Are you currently taking any prescription or non-prescription medications/supplements? YES NO

List Medications/Supplements: _____

_____

Do you have any allergies? YES NO List _____

Family Physician: _____

Date of last general health check-up: _____

INNOVATIVE PHYSICAL THERAPY OF LONG ISLAND, PC

Have you had any of the following medical or rehabilitative services for this injury/episode?

	YES	NO		YES	NO
Chiropractor			X-Rays		
General Practitioner			MRI		
Massage Therapy			CT-Scan		
Neurologist			EMG/NCV		
Occupational Therapy			Myelogram		
Physical Therapy			ER Care		
Orthopedist			Podiatrist		

Other: _____

Do you now have or have you ever had ANY of the following?

	YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema			Frequent Headaches		
Shortness of Breath/Chest Pain			Vision or Hearing Difficulties		
Coronary Heart Disease or Angina			Numbness or Tingling		
Do you have a Pacemaker?			Dizziness or Fainting		
High Blood Pressure			Bowel or Bladder Problems		
Heart Attack or Surgery			Weakness		
Stroke/TIA			Weight Loss/Energy Loss		
Congestive Heart Disease			Hernia		
Blood Clot/Emboli			Varicose Veins		
Epilepsy/Seizures			Allergies		
Thyroid Disease or Goiter			Any Pins or Metal Implants		
Anemia			Joint Replacement Surgery		
Infectious Diseases			Neck Injury/Surgery		
Diabetes (Type 1 or 2)			Shoulder Injury/Surgery		
Cancer or Chemotherapy/Radiation			Elbow/Hand Injury/Surgery		
Arthritis			Back Injury/Surgery		
Osteoporosis			Knee Injury/Surgery		
Gout			Leg/Ankle/Foot Injury/Surgery		
Sleeping Problems/Difficulties			Are You Pregnant?		
Latex Sensitivity/Allergy?			Do You Smoke?		

Patient/Guardian Signature: _____ **Date:** _____

PT Signature _____**Date:** _____

HIPAA Privacy Policies

It is the policy of Innovative Physical Therapy of Long Island, PC, that all providers and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to' ensure that our practice and its providers and staff have the necessary medical and PHI to provide the highest quality physical therapy care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should be confident to provide intonation to our practice and Its provider.; and· staff for purposes of treatment, payment and healthcare operations (TPO), knowing that our practice and its providers and staff will:

Adhere to the standards set forth in the Notice of Privacy Practices.

Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorizations, as. appropriate. Our practice and its providers and staff will not use or disclose PHI for uses outside of practice's TPO, such as marketing. employment, life insurance applications, etc. without an authorization from the patient.

Use and disclose PHI to remind patients of their appointments only with their consent

Recognize that PHI collected about patients must be accurate, timely, complete, and available when needed. Dur practice and its providers and staff Will:

Implement reasonable measures to protect the integrity of all PHI maintained about patients.

Recognize that patients have a right to privacy. Our practice and its providers and staff respect the patient's individual dignity at all times. Our practice and its providers and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.

Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice and Its providers and staff will:

Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.

Net disclose PHI data unless the patient (or his or her authorized representative) has properly consented to or authorized the release or the release is otherwise authorized by law.

Recognize that, although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her medical record if he/she believes his/her information is inaccurate or incomplete. Our practice and its providers and staff will:

Permit patients access to their medical records when their written requests are approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site healthcare professional review the patients' appeals;

Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.

All providers and staff of our practice will maintain a list of all disclosures of PHI for purposes other than TPO for each patient We will provide this list to patients upon request, so long as their requests are in writing.

All providers and staff of our practice will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice.

All providers and staff of our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.

Our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request ·