Premier™
Physical Therapy & Wellness

Patient Information

First Name:	Last Name:	MI:	Date of Birth:	Body Part/ Diagnosis:
Street Address:	City:	State:	Zip Code:	E-Mail Address: ☐Work ☐ Personal
Home Phone #:	Work Phone #:	Cell/ Other Phone #:		Did you receive PT/OT/ST/Chiro this year? ☐YES ☐NO
If yes, then what date or date range?	If yes, then how many visits used?	Did you have/ are you having surgery? ☐YES ☐NO		If yes, then list surgery date:
Referring Physician:	Referring Physician Address:	Referring Physician Phone #:		Referring Physician Fax #:

Primary Insurance Information

Primary Insurance Company/ Plan:	Primary Insurance Phone #:	Primary Policy Holder's Name:	Primary Policy Holder's Date of Birth:
Primary Insurance ID #:	Primary Policy Group #:	Insured's Social Security #:	Primary Policy Holder's Relation To Insured:
Is this an Auto No-Fault or Worker's Comp case? ☐YES ☐ NO	WC/ Auto NF Insurance Name:	WC/ Auto NF Accident Date & State:	WC/ Auto NF Claim or Case #:
Adjuster or Case Manager's Name:	Adjuster/ Case Manager's Phone #:	Employer's Name:	Employer's Address:

Secondary Insurance Information

Secondary Insurance Company/ Plan:	Secondary Insurance Phone #:	Secondary Policy Holder's Name:	Secondary Pol. Holder's Date of Birth:
Secondary Insurance ID #:	Secondary Policy Group #:	Secondary Policy Holder's Relation To Insured:	

Family Physician

Family Physician's Name:	Family Physician's Address:	Family Physician's Phone #:	Family Physician's Fax #:

Emergency Contact

First & Last Name of Contact:	Phone # of Contact:	Relationship to Contact:	

Please Indicate Your Preferred Methods Of Contact (self or authorized person):

☐ Home Phone ☐ Cell Phone
☐ Work Phone

Please Indicate The Office You Scheduled Your First Physical Therapy Visit At:

☐ NYC (170 E. 77th St.)	Fax: (212) 249-9539	☐ NYC (461 Park Ave. S.)	Fax: (212) 696-4499
☐ NYC (177 E. 87th St.)	Fax: (212) 876-5310	☐ KATONAH	Fax: (914) 232-3341
☐ NYC (226 E. 54th St.)	Fax: (212) 371-7011	☐ HARTSDALE	Fax: (914) 946-0304
☐ NYC (22 E. 49th St.)	Fax: (212) 753-1719	☐ EASTCHESTER	Fax: (914) 771-6202
☐ NYC (162 W. 72nd St.)	Fax: (212) 362-3587	☐ NORWALK	Fax: (203) 847-4442
☐ NYC (132 W. 96th St.)	Fax: (212) 249-2506	☐ DARIEN	Fax: (203) 202-9975

How Did You Hear About Premier Physical Therapy For This Specific Visit?

☐ I'm a past patient
☐ Premier business card at my doctor's office
☐ My doctor told me personally about Premier
☐ List from my doctor's office
☐ My doctor's receptionist told me about Premier
☐ My doctors nurse, PA, or medical assistant
☐ Yellow pages or white pages
☐ Premier sign outside of the office
☐ Friend (Who?)_____
☐ Insurance website
☐ Insurance book
☐ Called my insurance company
☐ Premier's website
☐ NYU Rehabilitation Network
☐ HSS Rehabilitation Network
☐ Received an email
☐ Received a mailing or postcard
☐ Premier Employee (Who?)_____
☐ Internet Search or Website (Which search engine or website?)_____
☐ Other _____

PATIENT RESPONSIBILITY, AGREEMENT & CREDIT CARD AUTHORIZATION

PATIENT RESPONSIBILITY

- I request that payment of benefits be made on my behalf to Premier Physical Therapy & Wellness for any services rendered.
- I understand and acknowledge that submission of claims is not a guarantee of payment. If for any reason my carrier does not cover any and/or all of my physical therapy treatments, I agree that I am responsible for the payment of the entire amount.
- New York State law mandates a physician's prescription for physical therapy treatments. Each is valid for only four (4) weeks from the date listed on the prescription.
- I understand that it is my responsibility to obtain a new prescription at the end of the specified time period. If I fail to obtain an updated prescription, I understand that I will be responsible for payment of services not covered by my carrier.
- I understand that it is my responsibility to make sure that my bills are paid in a reasonable time (no longer than 4 months from the date of treatment). If for any reason any portion of my bill is not paid, I understand that I am financially responsible for charges for services rendered.
- I understand and agree that if my carrier makes any payments directly to me for services rendered, I will remit the same payment to Premier Physical Therapy & Wellness.
- I understand that it is my responsibility to notify Premier Physical Therapy & Wellness of any changes to my insurance carrier or coverage as soon as possible. Any failure to report such changes will result in the patient being financially responsible for any lapse in coverage or authorization.
- I understand and agree that if I claim Worker's Compensation or Auto No-Fault benefits and am subsequently denied, I will be financially responsible for the services rendered.

I hereby authorize Premier Physical Therapy & Wellness to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Name: _____

Responsible Party Signature: _____

Relationship to Patient: _____ **Date:** _____

PATIENT AGREEMENT

- **LATE CANCELLATION POLICY** - I acknowledge that there is a 24-hour Cancellation Policy and understand that if I do not cancel 24 hours before my scheduled appointment, I accept the responsibility of being charged $75.00.
- I understand a late cancellation may be re-scheduled to avoid the cancellation fee if the appointment is re-scheduled within the same Monday-Friday period.
- I understand that I am responsible for my deductible, co-payments, and all late cancellation or no-show fees.
- I understand that all deductibles, co-payments, and co-insurance are due at the time of service.
- I understand that if I miss two (2) consecutive appointments without calling to cancel, then my future scheduled appointments will be removed and, to make future appointments, I will call to schedule each appointment on the same day I'm requesting it.
- Please inform the front desk of all scheduling changes. Your therapist is not responsible for your physical therapy schedule.
- If any changes are made with regard to patient insurance or payment coverage, the patient is to alert our office as soon as possible.
- If I am claiming Worker's Compensation or Auto No-Fault, it is my responsibility to inform the front desk of the scheduled IME date and results.

Signature: _____ **Date:** _____

CREDIT CARD AUTHORIZATION (Optional)

I hereby authorize Premier Physical Therapy & Wellness to charge my credit card account for services rendered to apply as payment to my account balance.

Card Holder's Name (as it appears on card): _____

☐ **MasterCard** ☐ **Visa**

Credit Card #: _____ **Expiration Date:** _____ **Billing Zip Code** _____

Signature: _____

HIPAA NOTICE OF PRIVACY PRACTICES

PURPOSE: THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THIS NOTICE GOES INTO EFFECT ON APRIL 14, 2003 AND REMAINS IN EFFECT UNTIL WE REPLACE IT.

1.) OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our practice. We need the record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways that we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2.) OUR LEGAL DUTY

a. Law Requires Us To:

i. Keep medical information private.
ii. Give you this notice describing our legal duties, privacy practices and your rights regarding medical information.
iii. Follow the terms of this notice that is now in effect.

b. We Have The Right To:

i. Change the privacy practices and terms of this notice at any time, provided that the law permits the changes.
ii. Make the changes in our policy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes were made.

3.) USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes the different ways that we use and disclose medical information. Not every use of disclosure will be listed. However we have listed all the ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purposes not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us and confirming receipt of written authorization.

a. For Treatment:

The HIPAA regulation permits nearly unlimited sharing of information among providers who are involved in a patient's treatment. Uses and disclosures of information commonly include collection of information from the patient by a physician or other medical practitioner for: performing diagnostic tests and reviewing results, consulting with other providers on diagnosis or treatment, referring a patient to another provider, and transmitting information to another provider such as phoning prescriptions into a pharmacy or placing an order for an ice machine, brace, or other durable medical equipment.

b. For Payment:

We are permitted to disclose to the patient's health plan, any information needed to process a claim. For example: to determine whether a patient is eligible for coverage under a health plan, to determine whether tests or services are covered under a health plan, to submit a claim or inquire about the status of a claim, to process payment or claims remittances, and to process credit card transactions.

c. For Health Care Operations:

Staff may use and disclose only the "minimum necessary" information for the task at hand. This includes: maintenance of medical records, maintenance of accounting records, quality assurance activities, staff performance evaluations, conducting financial and management audits, investigating complaints, supporting legal activities, resolving grievances, and general business management.

d. For Law Enforcement:

Your health information may be disclosed to law enforcement agencies to facilitate investigations, inspections, or mandated reporting. Your health information may be disclosed to public health agencies as required by law.

4.) HIPAA NOTICE OF PRIVACY PRACTICES

Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition.

5.) INDIVIDUAL RIGHTS

You have the right to request restrictions on the use and disclosure of your protected health information, the right to receive confidential communications regarding your treatment and condition, the right to inspect and copy your health information, the right to amend or submit corrections to your health information, and the right to receive a printed copy of this notice. As permitted by federal regulations, we require that a request to copy or review protected information be submitted in writing. If you would like to submit a comment about our privacy practices, you may do so by sending a letter outlining your concerns. If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to: ***HIPAA Privacy Official; Premier Physical Therapy; 1536 Third Ave., Fl. 5; New York, NY 10028.***

6.) ACKNOWLEDGEMENT OF FORM

I have received the Notice of Privacy Practices and I have been provided the opportunity to review the contents.

Name (please print clearly): _____

Signature: _____ Date: _____

Premier Physical Therapy and Wellness, P.C.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBER(S) AND/OR GUARDIAN

Last Name of Patient: _____ First Name of Patient: _____

Date of Birth: _____

I hereby authorize medical providers and personnel of Premier Physical Therapy to discuss and/or release my protected health information with:

_____	_____
(Relationship)	(Name)
_____	_____
(Relationship)	(Name)
_____	_____
(Relationship)	(Name)

This authorization shall be in force and in effect from_____ until_____
at which time this authorization to use or disclose this protected health information expires.

Unless specified above, this authorization will expire 365 days from the date of signing.
I understand that I have the right to revoke this authorization, in writing, at any time.
I understand that such revocation is not effective to the extent that the Clinic has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
I understand that I have the right to refuse to sign this authorization.

_____	_____
Signature of Patient	Date

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PATIENT INTAKE QUESTIONNAIRE

Name: _____ Date: ___/___/___

Occupation: _____ Age: _____

1) When did symptoms start? Date: ___/___/___

2) Please describe the symptoms: _____

_____

_____

_____

3) Living Environment: i) Do you live alone? ❑ Yes ❑ No ii) Does your home have: ❑ Stairs and/or ❑ Ramp?

4) Did you stop working due to your condition? ❑ Yes ❑ No If yes, date: ___/___/___

5) Have you had similar episodes of your current condition? ❑ Yes ❑ No If yes, were you treated? ❑ Yes ❑ No

6) Did you have surgery for this condition? ❑ Yes ❑ No If yes, date: ___/___/___

7) Please describe past related and/or unrelated surgeries or orthopedic injuries (include approximate dates):

_____

_____

_____

8) Have you had any imaging for this condition (X-rays/MRI/other)? _____ If yes, date: ___/___/___

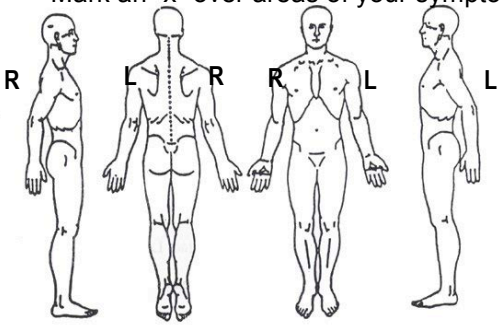
9) Describe the nature of the pain: (check all that apply)

❑ Sharp
❑ Dull/achy
❑ Throbbing
❑ Tingling
❑ Numbness
❑ Shooting

❑ Constant (76%-100%)
❑ Frequent (51%-75%)
❑ Occasional (26%-50%)
❑ Intermittent (25% or less)
❑ Increased in a.m.
❑ Increased in p.m.

Other: _____

Mark an "x" over areas of your symptoms:



10) Please circle the intensity of your pain at its **WORST**:

0	1	2	3	4	5	6	7	8	9	10
No pain		Slight		Mild		Moderate		Severe		Worst possible

11) Please check how the activities below affect your condition.

Activity	Standing	Walking	Lifting	Pushing /Pulling	Driving	Stairs	Bending Forward	Bending Backward	Overhead/Reaching
Better									
Worse									
No Change									

Activity	Squatting	Kneeling	Sitting	Typing/Writing	Other –
Better					
Worse					
No Change					

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PATIENT INTAKE QUESTIONNAIRE

12) Do you have or have you had any of the following medical conditions?

Condition	No	Yes	Condition	No	Yes
Unexplained Weight Loss/Gain >10 lbs			Stroke		
Unexplained Nausea & Vomiting			Pacemaker		
Unexplained Fatigue			Neurologic Disorder		
Dizziness/Vertigo			Psychiatric Treatment		
Difficulty Breathing			Hernia		
Incontinence			Cancer		
Night Sweats			Infectious Disease		
Night Pain			Rheumatoid Arthritis		
Headaches			Osteoporosis/Osteopenia		
Fainting Spells			Osteoarthritis		
Pain not Relieved by Change in Position			Multiple Sclerosis		
Falls			Metal Implant		
Seizures			Asthma		
Diabetes			Allergies to heat, ice, latex, adhesives or medications?		
High Blood Pressure					
Heart, Kidney or Thyroid			For women: Pregnant?		

13) If yes, to any of the above, please give appropriate details. Please list any condition not mentioned above:

14) Please list medications (related and unrelated):

[*] Medicare patients must include medication dosage, usage frequency, and administration method (i.e. oral)

Medication Name	Dosage [*]	Freq [*]	Method [*]	Medication Name	Dosage [*]	Freq [*]	Method [*]

To be completed by Physical Therapist: Height_____ Weight:_____

Patient's signature: _____

Thank you for choosing Premier, we look forward to working with you!