PATIENT REGISTRATION FORM *Please read carefully and complete by printing in ink. Provide all information requested.*

PATIENT REASON FOR VISIT: _____ **DATE:** _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PATIENT: This section refers to patient only

Last Name	First Name	MI	Address: Street and Number, Apt. # / Box #		
City	State	Zip	Home Telephone ( )	Work Telephone ( )	
Social Security No.		Date-of-Birth		Age	
Employer Name		Employer Address: Street and Number, Box #			
City	State	Zip	Type of Business		
Marital Status	Sex M F	Source of Referral (please circle whether Patient or Physician Name:			
Spouse/Guardian	Address: Street and Number, Box #			Apt	
City	State	Zip	Home Telephone ( )	Work Telephone ( )	
Social Security No. Spouse		Date-of-Birth Spouse		Age Spouse	
Spouse's Employer		Employer's Address: Street and Number, Box #			
City	State	Zip	Type of Business		
Emergency Telephone	Emergency Contact	Relationship			

INSURANCE INFORMATION: Please give us all pertinent information regarding your insurance coverage. If you have coverage by more than one carrier, supply information of both carriers. Please list all numbers on your card(s). Please check your insurance policy for a waiting period before coverage or pre-existing clauses. IF YOUR COVERAGE IS CONTINGENT ON A SECOND OPINION OR PRE-AUTHORIZATION APPROVAL, PLEASE BE SURE TO TELL US.

Comp./No-Fault/Private	D/O/A		Carrier Case#		
If No-Fault, Insurance Carrier Name	Address: Street and Number, Box#				
City	State	Zip	Phone Number ( )	Contact Person	
Policy Holder	Policy#		Group#		
Attorney Name	Address: Street and Number, Box#				
City	State	Zip	Phone Number ( )		
Referring Physician Name	Address: Street and Number, Box#	City	State	Zip	

PRIVATE INSURANCE: Complete Below:

PRIMARY Insurance Plan	Policy No.		Group No.	
Copay amount ($)	Effective Date		Termination Date	
Subscriber Name	Patient Relationship to Subscriber			
Insurance Company Address	City	State	Zip	Insurance Company Telephone No. ( )

SECONDARY Insurance Plan	Policy No.		Group No.	
Copay amount ($)	Effective Date		Termination Date	
Subscriber Name	Patient Relationship to Subscriber			
Insurance Company Address	City	State	Zip	Insurance Company Telephone No. ( )

TO MY INSURANCE CARRIER(S):

1. I authorize the release of any medical information necessary to process my insurance claim(s), to Millennium Practice Management Associates, Inc. 2. I authorize and request payment of medical benefits directly to my physicians, BRONX PHYSICAL THERAPY. 3. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. 4. I agree that a photocopy of this form may be used in lieu of the original. 5. I agree to pay all charges not covered by my insurance carrier(s). These charges include but are not limited to deductibles and copayments of my insurance policy.

_____

Signature

Name: _____ SSN: _____ Date: _____

Leisure activities, including exercise routines: _____

Occupation, including activities that comprise your workday: _____

Age: **Height:** **Weight:**
Are you on a work restriction from your doctor? Yes No **Are you latex sensitive?** Yes No
Do you smoke? Yes No **Do you have a pacemaker?** Yes No
FOR WOMEN: Are you currently pregnant or think you might be pregnant? Yes No
ALLERGIES: List any medication(s) you are allergic to: _____

Have you RECENTLY noted any of the following (check all that apply)?

- ☐ fatigue
- ☐ fever/chills/sweats
- ☐ nausea/vomiting
- ☐ weight loss/gain
- ☐ difficulty maintaining balance while walking
- ☐ falls
- ☐ numbness or tingling
- ☐ muscle weakness
- ☐ dizziness/lightheadedness
- ☐ heartburn/indigestion
- ☐ difficulty swallowing
- ☐ changes in bowel or bladder function
- ☐ constipation
- ☐ diarrhea
- ☐ shortness of breath
- ☐ fainting
- ☐ cough
- ☐ headaches

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ☐ cancer
- ☐ heart problems
- ☐ chest pain/angina
- ☐ high blood pressure
- ☐ circulation problems
- ☐ blood clots
- ☐ stroke
- ☐ anemia
- ☐ bone or joint infection
- ☐ chemical dependency (i.e., alcoholism)
- ☐ depression
- ☐ lung problems
- ☐ tuberculosis
- ☐ asthma
- ☐ rheumatoid arthritis
- ☐ other arthritic condition
- ☐ bladder/urinary tract infection
- ☐ kidney problem/infection
- ☐ sexually transmitted disease/HIV
- ☐ pelvic inflammatory disease
- ☐ thyroid problems
- ☐ diabetes
- ☐ osteoporosis
- ☐ multiple sclerosis
- ☐ epilepsy
- ☐ eye problem/infection
- ☐ ulcers
- ☐ liver problems
- ☐ hepatitis
- ☐ pneumonia

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

- ☐ cancer
- ☐ heart problems
- ☐ high blood pressure
- ☐ diabetes
- ☐ stroke
- ☐ depression
- ☐ tuberculosis
- ☐ thyroid problems
- ☐ blood clots

During the past month have you been feeling down, depressed or hopeless? **YES NO**
During the past month have you been bothered by having little interest or pleasure in doing things? **YES NO**
Is this something with which you would like help? **YES** **YES, BUT NOT TODAY** **NO**
DO you HAVE a DNR? DO NOT RESUSitate? YES NO
Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? **YES NO**

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Have you ever taken steroid medications for any medical conditions? **YES NO**
Have you ever taken blood thinning or anticoagulant medications for any medical conditions? **YES NO**

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. _____ 2. _____ 3. _____

Bronx Physical Therapy, LLP

Registered Physical Therapists
"Your Comfort Is Our Concern"

3611 E. Tremont Avenue
Bronx, New York 10465
(718) 904-9581
Fax: (718) 931-0125

INJURY INFORMATION

Patient Name: _____

WHERE did the injury take place? _____

WHEN did the injury take place? (Date and Time) _____

HOW did the injury occur? _____

_____

Was the injury work related? _____

Did you file this claim under Worker's Compensation? _____

Was the injury a result of an auto accident? _____

If injury was work/auto related, are you taking legal action? _____

If so, please include the attorney's name, address and phone number.

_____

_____

_____

Patient Signature: _____ **Date:** _____

GUIDELINES AND REQUIREMENTS

I understand patients are responsible for obtaining a new prescription or referral when applicable from a medical doctor in order to receive physical therapy. I also understand I need to obtain a current prescription upon the expiration of each prescription as indicated by the doctor. This is a New York State Law and The Practice reserves the right to deny treatment without a valid prescription or referral.

I understand that if my insurance company limits my physical therapy during the calendar year, all physical therapy charges thereafter will be my financial responsibility.

The patient will be responsible for obtaining all authorizations and referrals, as applicable, and subject to all plan provisions. If the required authorizations and or referrals are not obtained and services are not covered by your plan, the patient or guarantor will be financially responsible.

Copayments, when applicable, will be paid at the time of check in for the therapy session. Copayments are to be made at the time services are rendered.

In order to receive maximum benefit from your rehabilitation program, it is of utmost importance that you attend your therapy appointments and follow home instruction.

We request that if you are unable to keep your appointment that you notify the secretary 24 hours prior to your scheduled appointment. It is your responsibility to schedule your appointments at least one week in advance.

THERE WILL BE A $20 FEE CHARGED TO YOUR ACCOUNT FOR ALL "NO SHOW" APPOINTMENTS. Patients, not insurance companies, are responsible for paying this fee.

You are subject to be discharged from our services after three missed appointments (within a four-week period).

Your cooperation is appreciated. We look forward to working with you and obtaining optimum outcomes from your rehabilitation program. This form has been fully explained to you and you understand it.

Ultimately it is your responsibility to know your insurance plans policy of coverage and to provide current and valid information to our office at all times, or you will be held responsible for all balances.

_____ _____

Patient Signature Date

Bronx Physical Therapy, LLP

Registered Physical Therapists

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Bronx, New York 10465
(718) 904-9581
FAX: (718) 931-0125
E-MAIL: ptbronx3611@aol.com

Signature Sheet

I request that payment of authorized Medicare benefits be made on my behalf to **Bronx Physical Therapy, LLP** for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Medigap Authorization

Health Insurance Claim Number (HICN or SS#)_____

I request that payment of authorized Medigap benefits be made on my behalf to **Bronx Physical Therapy, LLP** for any services furnished to me by the provider of service. I authorize any holder of Medicare information about me to release to **Bronx Physical Therapy, LLP**, any information needed to determine these benefits payable for related services.

Patient Signature_____ Date_____

BRONX PHYSICAL THERAPY, LLP

CONSENT / AUTHORIZATION FOR TREATMENT

PATIENT'S NAME _____ DATE OF BIRTH _____

- I hereby authorize Bronx Physical Therapy, LLP, consultants, contractors, and sub-contractors, and other healthcare professionals providing services on behalf of Bronx Physical Therapy, to provide care and administer treatment and procedures as deemed necessary or advisable to me or the named patient each time I or the named patient present for care. I have been informed of risks and complications that may occur and alternatives that may be available.
- I acknowledge that no guarantees or assurances have been made to me concerning the results intended from my treatment.
- I confirm that I have read and fully understand the above.

DATE _____ SIGNATURE _____

IF THE PATIENT IS UNDER THE AGE OF 18 YEARS OLD (MINOR), PLEASE SIGN THE CONSENT FOR TREATMENT OF MINOR CHILDREN:

Name of parent/guardian: _____

DOB: _____/_____/_____ Soc. Sec.#: _____

(Witness) _____ (Signature) (Parent/Legal Guardian) _____

Bronx Physical Therapy
3611 E. Tremont Avenue
Bronx, NY 10465
718-904-9581

Notice of Privacy Practices and Patient Acknowledgement

To Our Valued Patient:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity when performing services to our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

It is our policy to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of privacy and integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

NOTICE OF PRIVACY

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule provides standards for health care providers to follow when disclosing health information about the patient that is needed to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information. We want to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. You may request restrictions pertaining to parties you do not want PHI released to. You will be asked to authorize release of PHI to any party that is not directly connected to your treatment, payment or health care operations.

If you have any questions, comments or objections to the privacy policies on this form, please ask to speak with our HIPAA Privacy Officer. You have the right to review our entire notice of privacy policies upon request.

Please sign this form to acknowledge that you have read this notice of our privacy policies.

Patient Name: _____

Signature: _____ Date: _____

If minor, signature of parent or guardian: _____

Thank you for being one of our highly valued patients.

****

For office use

A "good faith effort" was made to get a signature from patient. Signature was not attained due to the following: _____

_____