

W S P T

PHYSICAL THERAPY
AQUATIC THERAPY • WELLNESS

WORLD CLASS CARE RIGHT AROUND THE CORNER

Patient Registration Form

Name _____
Address _____ Apt# _____
City, State _____ Zip _____
Home Phone () _____ Cell Phone () _____
Social Security # _____ Date of Birth _____
Marital Status M S W D Age _____ Gender M F
Employer _____
Employer Address _____
Referring Physician _____
Physician's Phone # _____

Person Responsible for Payment

Check here if same as patient info

Relationship to Patient Spouse Parent Other _____
Name _____
Address _____
City, State Zip _____
Phone () _____
Social Security # _____ Date of Birth _____
Employer _____
Employer Address _____

Insurance Information

If your injury is related to an accident, please circle one of the following:

Work Related Auto Accident Other Date of Accident _____
Primary Insurer _____ Phone # _____
Policy # _____
Secondary Insurer _____ Phone # _____
Policy # _____

I agree to pay \$10 for not showing or cancelling with-in 24 hours of a scheduled appointment.

I hereby authorize the release of my medical or other information necessary to process insurance claims.

I understand that payment in full is expected when services are rendered unless prior arrangements have been made. Staff is available to explain our fees and assist with financial and insurance questions.

I also request payment of benefits to be sent to the party who accepts assignment.

Patient or Authorized Person's Signature

Date

Please provide us with your insurance card so we can make a copy.

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PATIENT INFORMATION

Name: _____ Occupation: _____ Age: _____

Date of Onset: Injury/Problem/Surgery: _____

Briefly state previous treatment, if any: _____

Do you have now, or have you ever had, any of the following?

DIABETES	YES ___ NO ___	ALLERGY TO COLD	YES ___ NO ___
HIGH BLOOD PRESSURE	YES ___ NO ___	OTHER ALLERGIES	YES ___ NO ___
PACEMAKER	YES ___ NO ___	PREVIOUS SURGERY	YES ___ NO ___
CHRONIC HEADACHES	YES ___ NO ___	SEIZURES	YES ___ NO ___
KIDNEY PROBLEMS	YES ___ NO ___	METAL IMPLANTS	YES ___ NO ___
NERVOUS DISORDERS	YES ___ NO ___	DIZZINESS	YES ___ NO ___
HERNIA	YES ___ NO ___	CANCER	YES ___ NO ___
ALLERGY TO HEAT	YES ___ NO ___	PREGNANT	YES ___ NO ___
BONE DISEASE	YES ___ NO ___	OSTEOPOROSIS	YES ___ NO ___
FRACTURES	YES ___ NO ___	BOWEL PROBLEMS	YES ___ NO ___
BLADDER PROBLEMS	YES ___ NO ___	RECENT WEIGHT LOSS	YES ___ NO ___
PINS & NEEDLES	YES ___ NO ___	CIRCULATORY DISEASE	YES ___ NO ___
PROBLEMS WITH BOTH ARMS OR BOTH LEGS AT THE SAME TIME	YES ___ NO ___		

If YES to any of the above, please explain and give appropriate details: _____

Are you presently taking any medications? YES ___ NO ___

If YES, please list your medications and for what condition: _____

Have you had any x-rays, CAT scans, MRIs, or other diagnostic tests for your recent disorder?

YES ___ NO ___ If YES, please explain the findings as you understand them: _____

Is there anything else you think we should know about your general health, or current condition?

Please explain and if, necessary, we can talk about it: _____

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INDIVIDUAL CONSENT

CONSENT TO USE OR DISCLOSE YOUR HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Patient Name

In providing service to you, we create and store health information that identifies you. We understand that this information about you and your health is personal, and we are committed to protecting the privacy of this information. We must obtain your one-time consent before we treat you, obtain payment for our services, and conduct health care operations of the practice. Please read carefully the information below before signing this form.

Notice of Privacy Practices We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail and we encourage you to read it. We want you to know, however that the Notice of Privacy Practices is subject to change. If it is changed, you may obtain a copy of the revised notice by calling the office at (718)409-9444 or asking for a copy at your next visit.

Revoking Consent You have the right to revoke this consent at any time, except to the extent that the center has already taken action based upon your consent. For example, if you revoke your consent after the office has provided you with treatment, the office will be permitted to use or disclosure your protected health information to bill for that treatment. To revoke this consent, please write to our office.

Scope of Consent *By signing this consent form, I hereby authorize Westchester Square Physical Therapy, PC and its providers to use and disclose my personal health information, as necessary, for the purposes of obtaining medical treatment, facilitating the payment for such treatment and for normal business operations.*

Signature of Patient or Personal Representative

Date

Print Name of Personal Representative

Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By initialing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how certain health information about me may be used and disclosed by Westchester Square Physical Therapy, PC and how I may obtain access to and control this information.

(Initial) [] I received / was offered a copy of the "Notice of Privacy Practices"