thrive INTEGRATED PHYSICAL THERAPY

**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: _____

***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 confidentially. 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: _____

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**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 $130 late cancel fee will be assessed**. Similarly, if you do not show up for a scheduled appointment, a $130 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:

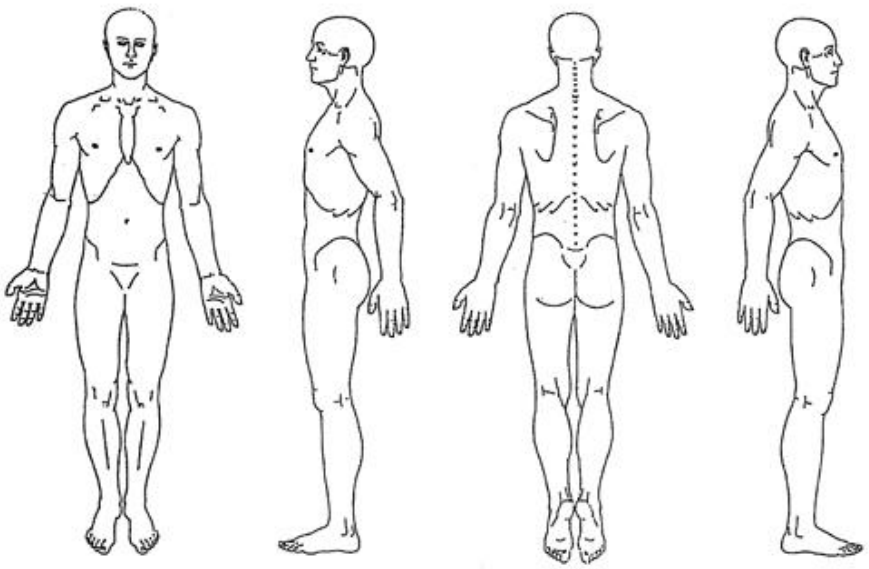
___ Pain ___ Loss of Motion ___ Swelling ___ Stiffness ___ Loss of Function

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:

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

_____ check all boxes that apply _____

| Have you or an immediate family member ever been told that you have: | | | For your current condition, have you received treatment from: | |
|---|---|---|---|---|
| Cancer | ❑ You | ❑ Family | ❑ Orthopedist | ❑ Physical Therapist |
| Diabetes | ❑ You | ❑ Family | ❑ Osteopath | ❑ Acupuncturist |
| Asthma | ❑ You | ❑ Family | ❑ Physiatrist | ❑ Massage Therapist |
| Osteoporosis | ❑ You | ❑ Family | ❑ Neurosurgeon | ❑ Chiropractor |
| High Blood Pressure | ❑ You | ❑ Family | ❑ Podiatrist | ❑ Internist |
| Heart Disease | ❑ You | ❑ Family | ❑ OBGYN | ❑ Other _____ |

What is you current occupation: _____ Presently working: ❑ Yes ❑ No

What is your activity level: ❑ Sedentary ❑ Light ❑ Active ❑ Very Active

What type of athletic activities to you participate in: _____

Do you drink alcohol: ❑ Yes ❑ No ❑ Occasionally

Do you use tobacco: ❑ Yes ❑ No ❑ Occasionally

**Patient Signature**: _____ **Date**: _____

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**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 an 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

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**HIPPA- ACKNOLOGEMENT OF RECEIPT**

By signing below, I acknowledge that I have been provided a copy of my physician's Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by this practice in accordance with the Health Insurance Portability and Accountability Act ("HIPAA"), and how I may obtain access to and control this information. In addition, by signing below I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services rendered to me, and for the business operations of this practice, its therapists, and staff.

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 many also file a complaint with us directly. Complaints should be directed to

Tamar Amitay
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.

Signature: _____

Print Name: _____

Date: _____

I make the following special request(s) for confidential communications:

Signature: _____

Date: _____