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: ____________________

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 <u>24 hours in advance or a $130 late cancel fee</u> 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

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PELVIC PT INFORMATION SHEET

Name: ____

HISTORY

What is your chief complaint: ____

Number of pregnancies: ________________ Number of vaginal deliveries: ________________

Birth weight of largest baby: ____________ Number of cesarean deliveries: _______________

Number of episiotomies: ________________ Date of last pap smear: ______________________

Did you have any trouble healing after delivery: Y / N

Do you have a history of sexual abuse or trauma: Y / N

Are you having regular periods/ menstrual cycles: Y / N

Do you have frequent urinary tract infections: Y / N

TEST RESULTS

Urodynamics Test: Y / N Results: ____

Cystoscope: Y / N Results: ____

Urine Test: Y / N Results: ____

Bowel Test: Y / N Results: ____

PAIN

Do you have back, leg, groin or abdominal pain: Y / N

Do you have pain with:

Sexual intercourse Y / N

Pelvic exams Y / N

Tampon use Y / N

BLADDER SYMPTOMS

Do you lose urine when you:

Are on the way to the bathroom Y / N

Have a strong urge to urinate Y / N

Hear water Y / N

Cough / sneeze / laugh (circle all that apply)

Lift / exercise / dance / jump (circle all that apply)

Other _____________________________________

Do you:

Wet the bed Y / N

Have burning /pain with urination Y / N

Have difficulty starting a stream of urine Y / N

Strain to empty your bladder Y / N

Feel unable to empty bladder fully Y / N

Have a falling out feeling Y / N

Have pain with a full bladder Y / N

Have an urgency of urination (a strong urge to urinate) Y / N

Urinate more than 7 times per day Y / N

BOWEL SYMPTOMS

Do you:

Strain to have a bowel movement Y / N

Leak / stain feces Y / N

Include fiber in your diet Y / N

Have diarrhea often Y / N

Take laxatives / enema regularly Y / N

Leak gas by accident Y / N

Have pain with bowel movement Y / N

Have a very strong urge to move your bowels Y / N

How often do you move your bowels: ______________ per day, week

Most common stool consistency (circle): liquid / soft / firm / pellets / other ____________

Thank you for taking the time to fill out this questionnaire.

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. **UPDATE: Due to the COVID-19 pandemic we are handling all billing remotely via CC on File only, unless special arrangements are made in advance**

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.

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.

Thrive will charge your credit card twice monthly for co-payments, deductible and other authorized purchases (ie. therapy supplies). Billing cycles are 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.

____
Name on Card (please print)

_________________________________ ____________ ____________
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: ______________________