Patient Registration Form:

First Name ___________________________ M.I. ____ Last Name ___________________________________
Address ____ Apt _________________
City ____ State _____________ Zip _________________
Phone# (Home:)_____________________________ (Cell:) _______________________________________
Email: ____

Social Security: __________________________ Date of Birth ________________________ Age __________
Single ______ Married ______ Divorced ______ Employed ______ FT Student ____ PT Student _____

Employer ____ Occupation __________________________
Employer Address ____
Phone ____

In case of an emergency, whom can we contact?
Name _______________________________________ Address ______________________________________
Phone ____ Relationship to Patient _______________________

Insurance Company ____ Phone ____________________
Policy/ID# ____ Claim/Case# _________________________
Adjuster/Claim Representative _____________________________________ Phone ____________________

Name of insured ____ Insured's Date of birth _____________
Insured's address ______________________________ City _______________ State ______ Zip ___________
Relationship to patient ____

Secondary Insurance ____ Phone _________________________
Name of insured ____ Policy/ID# ____________________
Relationship to patient ________________________________Insured's date of birth ___________________
Insured's Employer ____

Referring Doctor's Name _____________________________________ Phone _________________________
Primary Care Physician ______________________________________ Phone _________________________

Is injury due to: Auto Accident __________________ Work _________________ Other _________________
Date of Injury ________________________________ Date of Surgery _______________________________

How did you hear about us? Been here before____ Doctor ____ Insurance Book____
Friend/Relative ___ Phone Book ____ Internet ____ Other___________________________

For office use only: *PID#:____________* *Date of Registration: ____________* *Treating PT:___________*
FOA: ___________ *AUTH:____________* *BOA:___________*

Health History Questionnaire

Date of Evaluation: ___________

General information:

Name: ____

Medical history

Please place an X in any boxes that apply to you whether a current problem or in the past.

☐ irregular heart beat ☐ angina ☐ pacemaker ☐ heart surgery

☐ heart attack ☐ heart valve problem ☐ High blood pressure ☐ high cholesterol

☐ asthma ☐ emphysema ☐ chronic bronchitis ☐ hay fever

☐ arthritis ☐ broken bones, where? ____________________________________

☐ osteoporosis ☐ muscle or nerve diseases, specify ____________________________

☐ bleeding disorders ☐ kidney disorder ☐ seizures ☐ cancer

☐ diabetes, Do you take insulin?______ How often do you check your glucose?______

☐ gastrointestinal disorder, specify____

☐ Other problem/surgery ____

Have you ever become weak or ill when exposed to high temperatures? ☐ yes ☐ no

Has anybody in your family had a heart attack? ☐ yes ☐ no

Do you smoke? ☐ yes ☐ no Packs per day____________________

Have you ever received physical therapy ☐Yes ☐No For what purpose? ________________________

Medications: ____

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Signature________________________ **Therapist Signature**______________________ **Date:** ___________

Payment Policy

Thank you for choosing Performance Rehabilitation Pt OT PLLC as your provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. *We make every effort to inform you of the information we obtain is correct and up to date, but pleased be advised that knowing your insurance benefits is your responsibility.* If when your claim is processed any changes in the amounts from patient changes, you will be responsible for these amounts. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some items or services may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. If this is to occur, you will be fully apprised of these services prior to receiving them so you can determine if you want to receive that service.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. **Please be aware that should your account be referred to a collection agency, the percentage charged by the collection agency to our practice will be added to the total amount of your bill.**

8. Missed appointments. There is a $25.00 no-show/late-cancellation fee. All appointments must be canceled by 4 PM the day prior to your appointment (or by 4 PM on Friday for a Monday appointment), to avoid charges for a no-show or late cancellation. After hour messages regarding cancellations maybe left at (914) 776-7310 (Yonkers office) or 718-652-3432 (Bronx Office). Insurance will not cover charges for no-show/late-cancellation fees.

9. Copies of Medical Records and Insurance/Disability Forms. Our office will gladly make copies of medical records for you. The fee for this service is $15.00 per set. If you need our office to complete any disability forms or forms for your insurance company or other parties, we will be glad to do so for a fee of $15.00, payable in advance.

PLEASE BE AWARE THAT WE RESERVE THE RIGHT TO DENY TREATMENT IF YOUR FINANCIAL RESPONISBILITY IS NOT COLLECTED THE DAY OF YOUR APPOINTMENT.

I have read and understand the payment policy and agree to abide by its guidelines:

_______________________________ _______________________

Signature of patient or responsible party **Date**

Treatment & Cancellation Policy

Your doctor has prescribed Physical Therapy for you. Just as a certified pharmacist dispenses a drug therapy, physical therapy must be dispensed by a licensed physical therapist (PT). In addition, for the full effect of your therapy to be realized, your treatment plan must be adhered to fully.

Physical therapy aims to restore the normal mechanics and function of your injured body part. This restoration is accomplished by using a variety of treatments, and thus requires consistent attendance 2-3 times per week. While we realize that cancellations do and must occasionally occur, we respectfully request that you give us 24 hours notice prior to any cancellation. ***If you are having scheduling problems or any other problem with your treatment, please let us know immediately so that we may find the best possible solution regarding your situation.***

We feel that repeat cancellations lead to a poor recovery. In addition, it is not fair to us or to other patients who might have wanted to attend during your scheduled time. Patients who ***fail to show up for scheduled appointments two times without calling to indicate an interest in maintaining their treatment program may be discharged from therapy in addition to being assessed late cancellation / no-show fees.***. If you cancel ***more than twice in a two to three week period, we may discharge you from your therapy.*** This might require you to get a new prescription from your doctor and a new authorization from your insurance carrier

We realize that you have a choice of where to go for therapy, and we are happy you chose us. We will be committed to you and to the treatment of your injury. We want to see you return to normal health as quickly as possible which may be difficult if cancellation or failure-to-show problems occur.

Thank You.

Please sign below indicating you understand our policy:

____ **Date:** ___________

Your therapist's signature indicating this has been discussed with you:

____ **Date**: __________

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE

1. I acknowledge that I have received or have been offered a copy of Performance Rehabilitation PT OT PLLC's Notice of Privacy Practices, effective April 14, 2003. ______________(Initial)

2. I acknowledge my right and have been offered the option to request to receive communications of my personal health information by alternative means or at alternative locations. I understand that Performance Rehabilitation PT OT PLLC may refuse to accommodate my request if it is not reasonable. ____________ (Initial)

3. Please indicate the telephone number you would like our office to use for appointment reminders or other office communications (including but not limited to billing matters and test results).
Telephone #____

4. Please indicate the address that you would like our office to use for appointment reminders or other office communications (including but not limited to billing matters and test results):

Street Address:____
City:____________________________ State:______ Zip:___________________

5. Is there a family member or friend that you will allow us to leave messages with or release billing or medical information to? ____________________________ or None

*A current Notice of Privacy Practices for Performance Rehabilitation PT OT PLLC is also available at the check-in counter.

____ _________________
Signature of Patient or Representative Date

____
Print Name

____
Relationship of Representative/Authority to act on behalf of the Patient

FOR PERFORMANCE REHABILITATION PT OT PLLC STAFF USE ONLY

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain their acknowledgment and the reason you could not obtain it:

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