Paramount Physical Therapy
CONFIDENTIAL PERSONAL MEDICAL HISTORY

Date:_____

Patient Info: Last Name _____ First Name _____

Address _____ City _____ State/Zip _____

Email Address:_____ Social Security Number:_____

Age _____ Date of Birth _____/_____/_____ Marital Status (**circle one**): Married Single Divorced Widowed

Spouse/ Parent Name _____ Number of Children _____

Home Phone Number (_____)_____ Work Phone Number (_____)_____ Cell Phone Number (_____)_____

Occupation _____ Employer _____

PATIENT HEALTH INFORMATION

What is your major complaint? _____

How long have you had this condition? _____ Have you had this condition in the past? (circle one) Yes No

What activities aggravate your condition? _____

What makes your condition feel better? _____

Is your condition interfering with you (circle all that apply) Work Sleep Other (please specify) _____

List all medications you are presently taking _____

_____

Do you have a personal Physician? (circle one) No Yes (if yes) Name _____

Address _____

Date of last physical examination _____/_____/_____ Phone Number (_____)_____

Please list <u>any</u> past hospital admissions and/or surgery:

1._____ Date _____/_____/_____ 2._____ Date _____/_____/_____

3._____ Date _____/_____/_____ 4._____ Date _____/_____/_____

Are you pregnant? (circle one) Yes No

Do **<u>you</u>** personally have any past history of:

__ Arthritis	__ Multiple Sclerosis	__ Diabetes	__ Polio
__Heart Murmur	__ Rheumatic Fever	__ Kidney Disease	__ Tuberculosis
__ Measles	__Chest Pain	__ Pacemaker	__ Gout
__ Rapid Heart Beat	__ High Cholesterol	__ Swelling of Ankles	__ Loss of Weight
__ Asthma	__ Neurological Disorder	__ Emphysema	__ Poor Circulation
__ Hepatitis	__ Rheumatoid Arthritis	__ Kidney Stones	__ Ulcers
__ Miscarriage	__ Chronic Bronchitis	__ Pneumonia	__ Heart Attack
__ Rheumatic Heart Beat	__ Irregular Heart Beat	__ Thyroid Problems	__ Low Blood Pressure
__ Cancer	__ Osteoporosis	__Glaucoma	__ Prostate Problems
__ High Blood Pressure	__ Stroke	__ Liver Disease	__ Blood Clots

*Allergies: _____

PHYSICAL THERAPIST REVIEWED: _____ DATE: ____/_____/_____

Paramount Physical Therapy

CONFIDENTIAL PERSONAL MEDICAL HISTORY INSURANCE INFORMATION

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IF YOUR CONDITION IS THE RESULT OF AN INJURY, PLEASE COMPLETE THIS SECTION

Is your case: (circle one) Worker's Comp. No-Fault Personal Injury

Date of Injury _____/_____/_____ Time __:____ AM/PM Location _____

Please describe how the injury happened _____

_____

Did you report your injury? (circle one) **Yes** **No** If yes, to whom? _____

Were you hospitalized? (circle one) **Yes** **No** If yes, where/how long? _____

Are you presently working? (circle one) **Yes** **No** Dates of loss from work _____

Have you been treated by another Physical Therapist/Chiropractor for this injury? (circle one) **Yes** **No**

If yes, Physical Therapist's and/or Chiropractor's name and specialty _____

Have you had Physical Therapy in another facility this year? (circle one) **Yes** **No**

INSURANCE INFORMATION

(PLEASE FILL OUT ONE SECTION ONLY)

Private/Medicare Insurance

Name of Insured _____ Relationship _____

Date of Birth of Insured _____/_____/_____ Social Security # of Insured _____-_____-_____

Insurance Carrier's Name _____ Policy # _____ Group # _____

Secondary Insurance

Name of Insured _____ Relationship _____

Date of Birth of Insured _____/_____/_____ Social Security # of Insured _____-_____-_____

Insurance Carrier's Name _____ Policy # _____ Group # _____

Work Related Injury (Worker's Compensation)

Employer's Workman's Compensation Carrier _____

Address _____

Policy # _____ WCB Case # _____ Case # _____ Contact _____

Attorney Name _____ Address _____ Phone Number (_____)_____

Auto Related Injury (No Fault)

Insurance Company Name _____

Address _____

Policy # _____ WCB Case # _____ Case # _____ Contact _____

Attorney Name _____ Address _____ Phone Number (_____)_____

PATIENT ACKNOWLEDGEMENT AND RELEASE *(PLEASE SIGN)*

The information listed above is correct to the best of my knowledge. I hereby authorize the release of any information acquired in the course of my examination or treatment, relating to all claims for benefits submitted on my behalf further expressly agrees and acknowledges that my signature on this document authorizes my physical therapist to submit for benefits, for services rendered, without obtaining my signature on each and every claim.

Patient's Signature _____ Date _____/_____/_____

Parent, Spouse or Guardian Signature _____ Date _____/_____/_____

PHYSICAL THERAPIST REVIEWED: _____ DATE: ____/____/_____

PARAMOUNT PHYSICAL THERAPY CONSENT FORM AND OFFICE POLICY

CONSENT FOR TREATMENT OF A MINOR: As a parent and/or legal guardian, I authorize **Paramount Physical Therapy** to treat the minor patient named in the attached forms while I am not present.

***Parent/Guardian Signature _____ Date _____**

FOR ALL PATIENTS PLEASE READ AND SIGN :

CONSENT FOR CARE & TREATMENT: Your Physical Therapist will complete an evaluation by examination and interview. Your individual treatment program will then be designed. A variety of treatment techniques may be used. I the undersigned do hereby agree and give my consent for **Paramount Physical Therapy** to furnish physical therapy care and treatment considered necessary and proper in evaluating and treating my physical condition.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize **Paramount Physical Therapy** to furnish information to insurance carriers concerning this treatment and I hereby assign all payments for services rendered to be paid directly to **Paramount Physical Therapy**. A photo copy of this Assignment shall be considered as effective and valid as the original.

WORKERS' COMPENSATION CLAIMS: If you claim Workers' Comp benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

CANCELLATION & NO-SHOW POLICY: We require adequate notice by phone before your appointment in the event of a cancellation. The charge for three no-shows without proper notice is **$30**. This charge will not be covered by insurance, but will have to be paid by you personally prior to receiving additional treatment. The therapist might also place you on a "schedule based on availability list", meaning that you have to call for an appointment each day you want to come in and we will try to accommodate you at that time.

FINANCIAL POLICY: We bill your personal insurance carrier directly. You are responsible for your deductible/copay/coinsurance. We require that arrangements for payment of your estimated share be made today. It is the patient's responsibility to provide all necessary information/referrals prior to receiving services. If the proper information has not been provided and your insurance does not agree to pay, you will be responsible for all charges incurred. Any change in your insurance must be immediately reported to us. In the event that your insurance company requests a refund of payments made to us, you may be responsible for the amount of money refunded to your insurance company. If any payment is made directly to you by the insurance company for services billed by us, you recognize an obligation to promptly remit the payment(s) to us. If you have a maximum benefit per calendar year and continue beyond that you will be responsible for any treatment beyond that #, even if your insurance company has deemed those services "not medically necessary". If formal collections procedures become necessary you will be responsible for additional costs incurred. There is also a $25 fee for bounced checks. Your insurance benefits as quoted to us by your insurance carrier have been reviewed with you. We assume no liability for any errors made by your carrier in this quotation. We have reviewed these benefits with you and you agree to pay your portion of this bill.

Estimated patient payment / co-pay / deductible amount per visit $_____

Arrangements for payment of co-pay/deductible **(circle one): Will pay each visit/Will pay weekly in advance**

***The above information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

Patient / Parent or Guardian /Responsible Party_____ _____ Date_____

Clinic representative _____ Date_____

HIPAA Notice of Privacy Practices

Paramount Physical Therapy
11 Sunrise Plaza- Store 1
Valley Stream, NY 11580

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

This Notice of Privacy Practices describes how we may use and disclose your protected health information (**PHI**) to carry out treatment, payment or health care options (TPO) and for other purposes that are permitted by law. It also describes your rights to access and control your PHI. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other uses required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization; Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Worker's Compensation, Inmates, Required Uses and Disclosures: Under the law, we must take disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: The following is a statement of your rights with respect to your PHI:

- **You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.
- **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.**
- **You have the right to inspect and copy your PHI.** Under federal law, however, you may not inspect or copy the following records; Psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI.
- **You have the right to request a restriction of your PHI.** This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. **Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional.**
- **You have the right to receive an accounting of certain disclosures we have made, if any, of you PHI.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes affective on/before April 14. 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Policy.

Print Name: _____ Signature: _____ Date: _____

PARAMOUNT PHYSICAL THERAPY
11 SUNRISE PLAZA- STORE 1
VALLEY STREAM, NY 11580
LEIGH-ANN EDISON, PT, DPT, CSCS MICHAEL SETTANNI, PT

How did you find us? . . .

___**My Doctor NAME:**_____ ___Orlin & Cohen ___Hospital for Special Surgery Please note if you heard about us from: _____the doctor directly _____ office staff
___**A Friend or Family Member NAME**: _____
___**The Internet** ___Google ___Yahoo ___Other _____
___**My Insurance Company** _____
___**Drove by/ Location**
___**Other** _____

Thanks for your feedback!