Bay Ridge
8415 4th Ave
Brooklyn, NY 11209
Ph. (718) 921-9721
Fax- (718) 921-9349

Madison Physical Therapy

Sheepshead Bay
1514 Voorhies Ave
Brooklyn, NY 11235
Ph. (718) 648-0888
Fax- (718) 921-9349

PATIENT REGISTRATION FORM

Date: _____ **Name (Last, First)** _____
Birthday: _____ **Soc. Sec. #:** _____
Gender: ____ Male ____ Female **Age:** _____ **Height:** _____ **Weight:** _____
Marital Status: ____ Single ____ Married ____ Divorced ____ Separated ____ Widowed
Street Address _____ **Apt/Suite** _____
City _____ **State** _____ **Zip Code** _____
Cell Phone _____ **Home Phone** _____
Work Phone _____ **Ext**. _____ **Email** _____
Emergency Contact _____ **Relationship** _____
Emergency Contact Phone _____ **Emergency Contact Email** _____
Family Physician _____ **Referring Physician** _____
What is your primary reason for today's evaluation? _____

INSURANCE INFORMATION Please give your insurance card(s) to the front desk when you hand in this form.

PRIMARY INSURANCE **SECONDARY INSURANCE**
Insurance Company _____ Insurance Company _____

PATIENT MEDICAL HISTORY INFORMATION

Please list any prescription or non-prescription medication you are taking *(If you have a pre-written list of medications, please give it to the front desk to make a copy for your records):*

_____ _____ _____
_____ _____ _____
_____ _____ _____

Have you been examined by any of the following medical practitioners for this injury?

___ General Doctor
___ Neurologist
___ Orthopedist
___ Emergency Room
___ Pain Management
___ Podiatrist
___ Chiropractor
___ Physical Therapist
___ Occupational Therapist
___ Acupuncture
___ Massage Therapist
___ CT Scan or X-Ray
___ MRI
___ Myelogram
___ EMG/NCV
___ Bone Density
___Injections
___ Vax-D

Please circle each condition that you have been told you have (or had):

Allergies
Sexually Transmitted Disease
Asthmas, Bronchitis, Emphysema
Cancer/Chemotherapy/Radiation
Liver Disease
Heart Attack/Surgery
Heart Disease
High Blood Pressure
Kidney Disease
Ulcers
Osteoarthritis
Rheumatoid Arthritis
Angina
Stroke/TIA
Diabetes (Type I or II)
Lung Disease
Osteoporosis
Other(s): _____
_____
_____

Please circle yes or no to the following questions:

Do you smoke? **YES NO** Do you have metal implants? **YES NO** Do you have pacemaker? **YES NO**
Any unexplained weight/energy loss? **YES NO** Do you have any unrelenting pain in the night? **YES NO**

Please list any surgeries you may have had: _____
Please list other conditions not listed above: _____

Over the **past 2 weeks**, how often have you been bothered by any of the following problems?
0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day

1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

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PATIENT INDIVIDUAL CONSENT FORM

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

Print Patient Name (Last, First): _____ **Today's Date:** _____

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 carefully read the information below before signing this form.

Confidentiality: This office adheres to all rules regarding the confidentiality of patient records. Employees have access only to patient information necessary to properly perform the function of their jobs. This office will communicate with Medicare and/or all other insurance companies and other health care practitioner(s) by letter, phone or fax upon written permission from the patient (see below). Only information necessary to process claims is released to insurance companies.

Patient Consent: 1. I authorize the release of any medical information necessary to process all claims, and I authorize any staff of Madison Physical Therapy to communicate with Medicare and/or all other health care practitioner(s) as necessary by letter, phone or fax.

2. If assignment is accepted, I authorize and request my insurance companies to pay directly to my treating therapist or Madison Physical Therapy benefit otherwise payable to me. I understand that accepting assignment is a courtesy extended to me by this office and that I am financially responsible for any coinsurance, deductibles and services that are not covered or deemed "not medically necessary" by my insurance companies. Further, I understand that if an insurance claim is not paid within 45 days, I am responsible for the full amount immediately.

3. If assignment is not accepted, I understand that I am financially responsible for all services and payment is due at each visit unless other arrangements have been made.

4. If my treating provider or Madison Physical Therapy is a participating provider with Medicare and/or any other insurance companies, I understand that I am subject to the term conditions of Medicare and/or other insurance policies.

5. I am responsible to inform Madison Physical Therapy of any change to my insurance policy. I shall be responsible for any date of service not covered by my insurance while under your care.

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. Please ask the front desk to obtain a copy. 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) 921-9721 or (718) 648-0888 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 acted 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 disclose 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 Madison Physical Therapy 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.*

Acknowledgement of receipt of Notice of Privacy Practices: *By signing below, I also acknowledge that I have been informed of the Notice of Privacy Practices and have therefore been advised of how certain health information about me may be used and disclosed by Madison Physical Therapy and how I may obtain access to and control this information.*

Patient (or patient representative) Signature: _____

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CANCELLATION POLICY

Dear Patient,

You may wonder, or even get anxious, about why we need a cancellation policy. There are 3 main reasons.

1. If you don't follow up on the prescribed treatment plan from your physical therapist, you will not achieve the success you expect, and you (and we) will be disappointed.
2. When you make an appointment, you block out a spot for a patient who may have wanted to come in at that same time. We can only schedule a select few patients at a time.
3. You're affecting the therapist/office schedule and flow. The therapist was counting on you arriving for therapy and investing in your well-being.

In most cases, people do not cancel and do their best to show up for their appointment. After all, it is in their best interest. And we know that sometimes things are out of your control and you cannot attend an appointment. So please, do your best to call our office promptly if you are unable to show up for an appointment.

If you do not call at least **24 hours in advance**, we respectfully request that you share in the disruption and agree to pay **a $25 fee** for the missed appointment. It doesn't quite cover our cost, nor is it too punitive for most of our patients. We feel it reinforces a commitment on both of us. We only do this because we value your commitment to your health and set up a specific time for your appointment. The early call and cancellation will give another person the possibility to have access to timely medical care.

Let us know your thoughts and concerns. We are always here to help you in any way possible.

Thank you,

Mark Amir, PT, DPT, MPH, DipMDT
Chief Executive Officer

DATE: _____

PATIENT SIGNATURE: _____