HOME PHYSICAL THERAPY SOLUTIONS, PC
Excellence in Manual Therapy and Orthopedic Care

111 W. Old Country Road, Suite 001
Hicksville, NY 11801
Ph: 516-433-4570 / Fax: 516-433-4578

1865 Amstedam Ave., Lower Level
New York, NY 10031
Ph: 212-543-4800 / Fax 516-433-4570

2710 Grand Ave.
Bellmore, NY 11710
Ph: 516-781-9555 / Fax 516-433-4578

How did you hear about our office? _____

Last Name: _____ First Name: _____

Date of Birth: _____ Marital Status: ☐ single ☐ married ☐ divorced ☐ widowed

Social Security # : _____ Email: _____

Address: _____ Phone: Cell _____

_____ Home _____

_____

City: _____ State: _____ Zip: _____

Emergency Contact: Name: _____ Phone _____

Referring Physician: _____ Phone: _____

Address: _____ Fax: _____

_____

_____

Primary Care Physician: _____ Phone: _____

Insurance Information

Primary: _____ **Secondary** _____

ID / Claim # _____ ID / Claim # _____

Address: _____ Address: _____

City: _____ State: ___ Zip: _____ **City:** _____ **State:** ___ **Zip:** _____

Policy Holder: _____ **Policy Holder:** _____

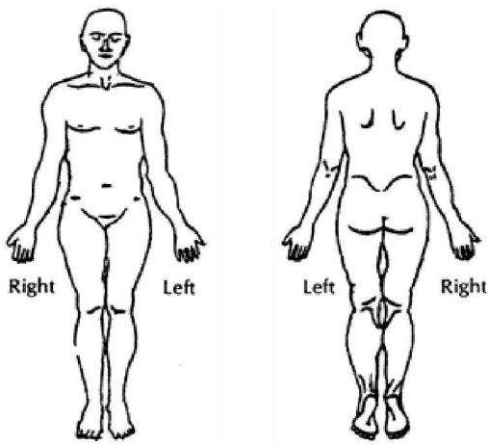
Relationship: _____ Relationship: _____

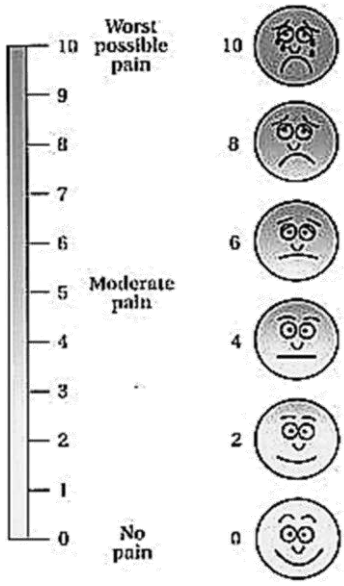
_____ _____

Signature of patient or authorized representative **Date**

Patient Name: _____

Current Complaints **Location**





Please indicate where the pain, numbness and/or tingling is by drawing as follows

xxxx = pain oooo = numbness //// = tingling

How did your symptoms start? _____

Describe your symptoms _____

Medical Information

Height_____Weight _____ ☐ Right handed ☐ Left handed

Allergies _____

_____

Social History

Occupation _____

Tobacco use ☐ No ☐ Yes

Alcohol use ☐ No ☐ Yes

Do you live alone? ☐ No ☐ Yes _____

Medical History ☐ None

☐ Arthritis ☐ Cancer

☐ Diabetes ☐ Heart disease

☐ High blood pressure ☐ High cholesterol

☐ Kidney disease ☐ Liver disease

☐ Pacemaker ☐ Respiratory disease

☐ Thyroid problems ☐ Pregnant

☐ Other _____

Current Medications ☐ None Dosage

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Surgical History ☐ None Date

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____

Signature of patient or authorized representative

_____

Date

HOME PHYSICAL THERAPY SOLUTIONS, PC
Excellence in Manual Therapy and Orthopedic Care

111 W. Old Country Road, Suite 001
Hicksville, NY 11801
Ph: 516-433-4570 / Fax: 516-433-4578

1865 Amstedam Ave., Lower Level
New York, NY 10031
Ph: 212-543-4800 / Fax 516-433-4570

2710 Grand Ave.
Bellmore, NY 11710
Ph: 516-781-9555 / Fax 516-433-4578

1. Have you or a family member ever been treated at Home Physical Therapy Solutions P.C. ☐ Yes ☐ No

If yes, Patient's Name: _____ Which location: _____

2. Have you had physical therapy, chiropractic or occupational treatments this year? ☐ Yes ☐ No

If yes, please indicate which treatment and duration _____

3. Have you had physical therapy for this condition previously? ☐ Yes ☐ No If yes, for how long _____

FOR MEDICARE PATIENTS ONLY:

Are you currently receiving home care services? ☐ Yes ☐ No

If yes when will you be fully discharged from homecare? _____

Do you have a homecare discharge letter? ☐ Yes ☐ No

IS YOUR INJURY A RESULT OF AN AUTOMOBILE ACCIDENT

☐ Yes ☐ No If yes answer section below:

IS YOUR INJURY A RESULT OF A WORK RELATED ACCIDENT

☐ Yes ☐ No If yes answer section below:

Insurance: _____ **Employer:** _____

Case # _____ Address: _____

WCB # _____ _____

Adjuster: _____ Phone: _____

Phone: [ ] _____ Was accident reported to employer? ☐ Yes ☐ No

Date of Injury: _____ Time : _____ ☐ AM ☐ PM **Attorney** _____

Place of Injury: _____ Phone: _____

Describe accident: _____

_____

Have you lost time from work? ☐ Yes ☐ No How much? _____

Have you seen anyone else for this condition? _____

Were x-rays taken? ☐ Yes ☐ No Other tests? ☐ Yes ☐ No If yes, what? _____

Any previous Worker Comp injuries? ☐ Yes ☐ No Dates _____

HOME PHYSICAL THERAPY SOLUTIONS, PC
Excellence in Manual Therapy and Orthopedic Care

111 W. Old Country Road, Suite 001
Hicksville, NY 11801
Ph: 516-433-4570 / Fax: 516-433-4578

1865 Amstedam Ave., Lower Level
New York, NY 10031
Ph: 212-543-4800 / Fax 516-433-4570

2710 Grand Ave.
Bellmore, NY 11710
Ph: 516-781-9555 / Fax 516-433-4578

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

CONSENT OF TREATMENT

I understand that I have been referred for rehabilitative treatment and care to HOME PHYSICAL THERAPY SOLUTIONS P.C. A therapist representing HOME PHYSICAL THERAPY SOLUTIONS P.C. will describe for me my individual treatment plan. I understand that I have the right to ask and have my questions answered prior to receiving treatment. By signing this agreement, I consent to have HOME PHYSICAL THERAPY SOLUTIONS P.C. provide assessment, treatment and care as prepared by my physician and/or recommended by my therapist. I further certify that no guarantees or assurances have been made to me regarding the results that might be obtained.

In conjunction with my care, I consent to allow the use of filming devices, such as a camera or cell phone, for the purposes of enhancing my care. In addition, I consent to the transmittal of such filming device images or video to Home Physical Therapy Solutions and/or the treating physician through email or text. I acknowledge that such film and related images will only be used or disclosed for treatment purposes, and that Home Physical Therapy Solutions will not further use or disclose such film or images for any other purpose without my authorization or consent ☐ Yes ☐ No

Authorization for Release of Information

I authorize HOME PHYSICAL THERAPY SOLUTIONS P.C. to release all medical information relating to all claims for benefits submitted on behalf of myself and/ or my dependents to third party payors or insurance companies necessary to pay all claims generated by rehabilitative services provided by HOME PHYSICAL THERAPY SOLUTIONS P.C.

Assignment of Benefits / Financial Responsibility

I request that payments of authorized benefits be made on my behalf directly to Home Physical Therapy Solutions P.C and/or its providers as payment towards the total charges for services furnished to me or my dependents. I FURTHER AGREE THAT ANY PAYMENTS MADE BY MY INSURANCE CARRIER DIRECTLY TO ME WILL BE TURNED OVER TO HOME PHYSICAL THERAPY SOLUTIONS P.C. ALONG WITH THE EXPLANATION OF BENEFITS. The office agrees that it will assist me at no charge in filling out of any insurance claim forms required. I further grant this office power of attorney to endorse any check remitted in my name for the purpose of applying that amount to my account.

I understand that HOME PHYSICAL THERAPY SOLUTIONS P.C., in insurance assigned cases, agrees to accept the determination of the insurance company as the full charge. I UNDERSTAND THAT ACCEPTING ASSIGNMENT IS A COURTESY EXTENDED TO ME AND THAT I AM FINANCIALLY RESPONSIBLE ONLY FOR ANY CO-INSURANCE, DEDUCTIBLES, AND SERVICES THAT ARE NOT COVERED BY MY INSURANCE COMPANY. Co-insurances and deductibles are based upon the determination of the insurance company. I understand that I am subject to the terms and conditions of the Medicare and/or other insurance policies, of which Home Physical Therapy Solutions P.C. is a participating provider.

I further understand that, in the case of denial of a claim by a third party payor, or as a result of a dispute with such payor, I will remain fully responsible for the charges with no time limitation from the date of services to the date of billing.

Patient / Guardian _____
Signature

Printed Name _____ Date _____

HOME PHYSICAL THERAPY SOLUTIONS, PC
Excellence in Manual Therapy and Orthopedic Care

111 W. Old Country Road, Suite 001
Hicksville, NY 11801
Ph: 516-433-4570 / Fax: 516-433-4578

1865 Amstedam Ave., Lower Level
New York, NY 10031
Ph: 212-543-4800 / Fax 516-433-4570

2710 Grand Ave.
Bellmore, NY 11710
Ph: 516-781-9555 / Fax 516-433-4578

ATTENDANCE POLICY

We at Home Physical Therapy Solutions are committed to working with you to get you back to optimum function. We will do everything we can to provide you with high level, skilled rehabilitation services in a compassionate and supportive environment. **Arriving on time** for your appointment is critical to the optimal delivery of care.

Appointments are in high demand, so for your convenience, we have structured our office hours to accommodate a wide variety of personal schedules. In order to maintain the quality of care and minimize waiting times, please arrive on time for your scheduled appointment. Scheduling is based on a first come, first served basis. It is advisable for you to schedule your appointments in two to four week intervals.

While we understand that emergencies do arise, last minute cancellations and patient no shows create gaps in our schedule and prevent us from accommodating other patients who would benefit from the treatment that could have been provided. This is detrimental to us and to the patients we try to serve. We ask for your full cooperation with the following policy:

- WE REQUIRE AT LEAST 24 HOURS NOTICE to cancel an appointment with your therapist.
  - If you are more than 30 minute late for your appointment and fail to notify us, your treatment may be shortened or cancelled. Chronic late arrivals are disruptive to the successful implementation of your plan of care.
  - Failure to show for your scheduled appointment (NO SHOW) or cancel with less than 24 hours' notice will result in a $50.00 fee being charged. THE PATIENT IS RESPONSIBLE FOR THIS FEE, NOT THE INSURANCE OR THIRD PARTY PAYOR. In addition, 2 consecutive no shows will result in cancellation of all future appointments.
  - No cancellation fee will be charged if the missed appointment is made up within the same week, not on a day you already have a scheduled appointment.
  - All cancellations and no shows will be documented in your medical record and appropriately reported to your physician, insurance or case manager.

We thank you in advance for your cooperation in this matter. If there is anything we can do to assist you in your recovery, please let us know. Your comfort and satisfaction means a lot to us.

Date _____

_____

Patient Acknowledgement/Signature

HOME PHYSICAL THERAPY SOLUTIONS, PC
Excellence in Manual Therapy and Orthopedic Care

111 W. Old Country Road, Suite 001
Hicksville, NY 11801
Ph: 516-433-4570 / Fax: 516-433-4578

1865 Amstedam Ave., Lower Level
New York, NY 10031
Ph: 212-543-4800 / Fax 516-433-4570

2710 Grand Ave.
Bellmore, NY 11710
Ph: 516-781-9555 / Fax 516-433-4578

Patient Care Text Messaging/Emailing Consent Form

DECLARATION

I authorize HOME PHYSICAL THERAPY SOLUTIONS, P.C. to contact me by text message/email for the purposes of health promotions and for appointment reminders.

I acknowledge the appointment reminders by text/email are an additional service and that these may not take place on all occasions, and that the responsibility of attending appointments or cancelling them still rests with me. I can cancel the text message/email facility at any time.

Text messages are generated using a secure facility. I understand that they are transmitted over a public network onto a personal telephone and as such may not be secure, However, the practice will not transmit any information that would enable an individual patient to be identified.

I agree to advise the practice if my mobile number changes. I also understand that I can make changes to both authorizations at any time. Requests for changes must be made in writing.

Patient/Guardian Name: _____

Please Print

Patient/GuardianSignature:_____ **Date: _____**

Ifyouchoosetohavemymedicalinformationcommunicatedtoindividualsotherthanyourself,Imustdosoby completing and signing the authorization below.

I do herby authorize HOME PHYSICAL THERAPY SOLUTIONS, P.C. to release my medical information to the person/persons named below.

Name	Relationship	Phone #
Name	Relationship	Phone #
Name	Relationship	Phone #

Newsletter:

In an ongoing effort to provide our patients with great customer service and the latest information regarding all of our client services, you may receive emails of our informative monthly newsletter from our company. If you prefer NOT to receive these emails, please check the box below:

☐ ***Opt outofNewsletter***

Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number N/A
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☐ At request of individual ☐ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**