

Patient Registration

Please print clearly or fill in on your phone or computer

PATIENT INFORMATION

Last name		First name		M.I.
Street address		City	State	Zip code
Cell phone	Home phone		Work phone	
Date of birth (MM/DD/YYYY)	Social Security # (optional)	Email address		
Gender	Marital status	Preferred language		
☐ Female ☐ Male	☐ Married ☐ Single			
Best way to reach you				
☐ Cell phone call ☐ Text message ☐ Home phone ☐ Email ☐ I agree to receive appointment reminder texts and calls at the numbers above.				

Employer	Occupation

EMERGENCY CONTACT & REFERRING PHYSICIAN

Emergency contact name	Relationship to you	Phone #
Referring physician	Physician phone #	

HOW DID YOU HEAR ABOUT US?

☐ Family or friend
 ☐ Physician referral
 ☐ Insurance website
 ☐ Google search
 ☐ Google Maps / reviews
☐ Instagram / social media
☐ Our website
☐ I was a former patient
☐ Clinic sign
☐ Other:

Insurance information and your signature for this registration are on the next page.



Midwood / Flatbush
2918 Avenue M, Brooklyn, NY 11210
Tel (718) 252-0625 · Fax (718) 252-0615

Boro Park
5327 18th Avenue, Brooklyn, NY 11204
Tel (718) 831-2333 · Fax (718) 831-2334

Staten Island
1751 Victory Blvd, Staten Island, NY 10314
Tel (718) 816-6111 · Fax (718) 816-6112

Insurance Information

Please bring your insurance card(s) and a photo ID to your first visit

PRIMARY INSURANCE

Primary insurance company	Insured's name	Insured's birth date
Policy number / ID number	Group number	Relationship to insured

SECONDARY INSURANCE (IF ANY)

Secondary insurance company	Insured's name	Insured's birth date
Policy number / ID number	Group number	Relationship to insured

MOTOR VEHICLE ACCIDENT (MVA) / WORKERS' COMPENSATION

Is this visit related to:

☐ Workers' comp ☐ Motor vehicle accident (MVA)

Date of accident (MM/DD/YYYY)

Insurance company name	Address	Phone #
Claim number / policy #	Adjuster name	Adjuster phone #

CONSENT & SIGNATURE

I, the undersigned, hereby request evaluation and treatment by Refuah PT and consent to care and treatment as ordered by my physician(s). I authorize the release of information related to my rehabilitation to my physician(s). I hereby authorize my health insurance to make payment directly to Refuah PT for any benefits I may receive. I realize that this may not represent the full payment for services rendered and that I will be responsible for the balance due within 30 days. I authorize the release of any information necessary to process my insurance claims and facilitate payment of my account by a third party.

Patient / guarantor signature (sign after printing, or type your full name)	Date (MM/DD/YYYY)
Print patient / guarantor name	

Relationship to patient (please check one)

☐ Self ☐ Parent ☐ Legal guardian ☐ Power of attorney

OFFICE USE ☐ ID verified

Health History

This helps your therapist treat you safely

CURRENT MEDICATIONS (PRESCRIPTION AND OVER-THE-COUNTER)

Do you currently take any prescription medications? ☐ No ☐ Yes — please list below

Medication name	Dose (e.g. 10 mg)	How often (e.g. twice a day)

ALLERGIES

☐ No known allergies ☐ Medication ☐ Latex ☐ Adhesive tape ☐ Other

Please describe (what you are allergic to and the reaction)

HEALTH SCREENING — DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

	Yes	No		Yes	No
Pacemaker or other implanted device	☐	☐	Metal implants (joint replacement, plates, screws)	☐	☐
Currently pregnant or could be pregnant	☐	☐	Cancer (now or in the past)	☐	☐
Osteoporosis	☐	☐	Blood thinners (e.g. Eliquis, warfarin)	☐	☐
Diabetes	☐	☐	Heart or lung condition	☐	☐
Recent unexplained weight loss	☐	☐	Numbness or tingling	☐	☐
New bowel or bladder changes	☐	☐	Dizziness	☐	☐

If you answered yes to any item, please explain

FALLS & BALANCE

Have you fallen in the past 12 months? ☐ No ☐ Yes How many times? Were you injured? ☐ No ☐ Yes

Do you feel unsteady when standing or walking? ☐ No ☐ Yes

MEDICAL HISTORY & ACTIVITY

Please list any illness, medical & surgical history (i.e.: diabetes, high blood pressure, surgeries and dates)

Do you exercise on a regular basis? ☐ Yes ☐ No If yes, what type?

THERAPY SO FAR THIS YEAR

Have you previously had physical therapy this year? ☐ Yes ☐ No If yes, how many sessions?

Since January 1 of this year, have you received home health care, or outpatient PT, OT or speech therapy anywhere else?

☐ No ☐ Yes If yes, where and when?

Medicare patients: this helps us track your yearly therapy benefit.

Patient Intake Questionnaire

About the problem that brings you to therapy

Date Name

Height Weight

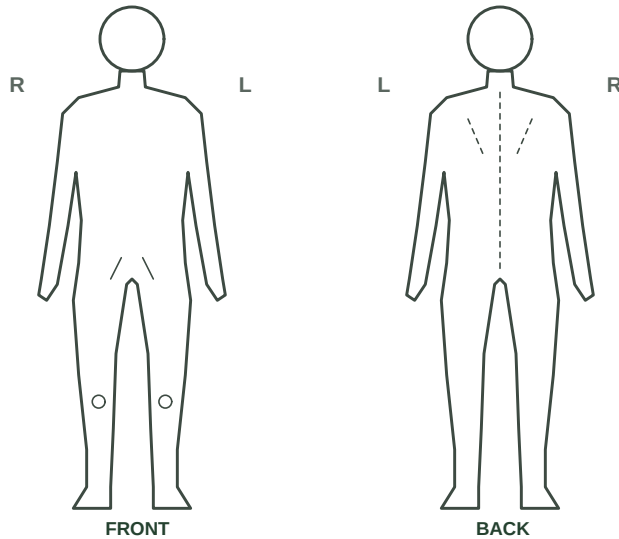
Chief complaint (main problem)

What are your symptoms?

When did your symptoms begin? Date of surgery or fracture

WHERE IS YOUR PAIN?

Mark the drawing where you feel pain (after printing), or describe it below.



Describe where (e.g. right knee, lower back, left shoulder)

YOUR GOALS

What goals would you like to achieve from therapy?

RATE YOUR PAIN

Pain right now (0 = no pain, 10 = worst pain imaginable):

☐ 0
 ☐ 1
 ☐ 2
 ☐ 3
 ☐ 4
 ☐ 5
 ☐ 6
 ☐ 7
 ☐ 8
 ☐ 9
 ☐ 10

No pain

Worst pain

1. Since onset, are your symptoms getting:

☐ Better
 ☐ Worse
 ☐ Staying the same

2. Are your symptoms:

☐ Constant
 ☐ Intermittent (come and go)

If intermittent: how often?

How long do they last?

When do they get worse?

When are they best?

3. As the day progresses, do your symptoms:

☐ Increase
 ☐ Decrease
 ☐ Stay the same

4. Please list any activities you can't do now as a result of your injury/symptoms:

5. Have you seen any of the following during the past three months?

- | | |
|---|--|
| ☐ Medical Doctor (MD) | ☐ Physical/Occupational Therapist |
| ☐ Acupuncturist | ☐ Osteopath (DO) |
| ☐ Chiropractor (DC) | ☐ Massage Therapist |
| ☐ Dentist | ☐ Naturopathic Doctor (ND) |
| ☐ Oriental Medicine Doctor | ☐ Other |

6. Have you had any of the following tests performed for this problem?

- ☐ X-ray
 ☐ MRI
 ☐ CT Scan
 ☐ Bone Scan
 ☐ Arthrogram
 ☐ Lab Tests
 ☐ Other

Results

Conditions of Registration

Thank you for trusting Refuah Physical Therapy with your physical therapy needs. We take our commitment to you very seriously and look forward to working with you to enhance your health and well-being.

By signing the Conditions of Registration, I authorize treatment with Refuah Physical Therapy and agree to the following:

- 1. RELEASE OF INFORMATION:** I authorize Refuah Physical Therapy to release my medical records to my health insurance for the purpose of billing and processing of my claim. I also agree to allow Refuah Physical Therapy to release my medical records and discuss health related and financially related issues to all health care providers, case managers, insurance representatives and lawyers that are involved in my case. A photocopy or a faxed copy of the release may be used in place of the original.
- 2. ASSIGNMENT OF INSURANCE BENEFITS:** Refuah Physical Therapy has my permission to submit billings to my insurance company on my behalf and I authorize these payments to be made directly to Refuah Physical Therapy. I agree to pay all outstanding balances on my account within 30 days of receiving a balance due statement. I also agree to pay all insurance co-payments, deductibles, co-insurance and/or non-covered charges at the time of service. Should my account be referred to an attorney or collection agency for collection, I will pay actual attorney fees and collection expenses.
- 3. BENEFITS AND ELIGIBILITY:** As a courtesy Refuah Physical Therapy contacts the insurance company to verify benefits. This courtesy is NOT a guarantee of benefits. I acknowledge and agree that it is my responsibility to know my own benefits with regard to receiving physical therapy services.
- 4. SELF-PAY POLICY:** If choosing our self-pay option to NOT go through insurance, I understand and agree that all payments for physical therapy services will be my responsibility at the time of service. This means Refuah will not submit any claims to any insurance carrier.
- 5. CANCELLATION AND MISSED APPOINTMENT POLICY:** In the event that I am unable to attend my scheduled appointment I agree to give at least 24 hours' notice or 1 business day prior to my scheduled appointment or be charged \$30.00. This policy enables Refuah Physical Therapy to schedule other clients who are in need of therapy services in a prompt and timely manner.

☐ **Please check the box to acknowledge that you have read our Conditions of Registration.**

Patient name (print)

Signature of patient / guarantor (sign after printing, or type your full name)

Date (MM/DD/YYYY)

Notice of Patient Information Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

REFUAH PHYSICAL THERAPY Legal Duty

REFUAH PHYSICAL THERAPY is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

Uses and Disclosures of Health Information

REFUAH PHYSICAL THERAPY uses your personal information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care that we provide. For example REFUAH PHYSICAL THERAPY may use your personal health information to contact you to provide appointment reminders or information regarding treatment alternatives or other health related benefits that could be of interest to you.

REFUAH PHYSICAL THERAPY may also use or disclose your personal health information with prior authorization for public health purposes, for auditing purposes, and for research studies or emergencies. We also will provide personal health information when required by law.

In any other situations, REFUAH PHYSICAL THERAPY'S policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

REFUAH PHYSICAL THERAPY may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in a common area of our facility. You may also request an updated copy of our Notice of Information Practices at any time.

Patient's Individual Rights

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. REFUAH PHYSICAL THERAPY will consider all such requests on a case-by-case basis but the company is not legally required to accept them.

Concerns and Complaints

If you are concerned that REFUAH PHYSICAL THERAPY may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information please contact our HIPAA Compliance Office. You may also send a written complaint to the US Department of Health and Human Services.

Acknowledgement – Notice of Patient Information Practices (HIPAA)

I hereby acknowledge receipt of REFUAH PHYSICAL THERAPY, Notice of Patient Information Practices.

This Notice of Patient Information Practices provides detailed information about how the practice may use and disclose my confidential health information.

Patient name (print)

Signature of patient / legal guardian (sign after printing, or type your full name)

Date (MM/DD/YYYY)