ORTHOPRO PHYSICAL THERAPY

Tel (646) 389-6010
Fax (646) 357-3577
orthopronyc.com

PATIENT REGISTRATION

Name: _____ D.O.B.: _____ Sex: M F

Address: _____ City: _____ State: _____ ZIP :_____

Home Phone: _____ Cell: _____

Email:_____ Employer/Occupation: _____

Referring Doctor: _____

Diagnosis/Problem Area: _____

Emergency Contact:

Name: _____ Phone: _____

Relationship to Patient: _____

INSURANCE INFORMATION

Primary Insurance: _____ Policy No.: _____

Group No.: _____ Name of Policyholder:_____

Secondary Insurance: _____ Policy No.: _____

Group No.: _____ Name of Policyholder:_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize OrthoPro Physical Therapy or insurance company to release any information required to process my claims:

Patient/Guardian Signature: _____ ***Date:***_____

CONSENT FOR CARE AND TREATMENT

I, the undersigned do hereby agree and give my consent for OrthoPro Physical Therapy to furnish the medical care and treatment considered necessary and proper in assessing or treating my physical condition. **Initials**_____

NO SHOWS/CANCELLATIONS

It is important to keep any appointments you schedule or contact us if you cannot. This way we can schedule others who wish to be treated. Kindly give **24 hours' notice** if you have to cancel or reschedule your appointment. If you have a scheduled appointment and fail to contact our office to cancel or reschedule prior to your appointment time, a **$100.00** charge will be assessed to your account, unless amended at the discretion of OrthoPro Physical Therapy. This charge will not be assessed to your insurance company and is **YOUR** responsibility. **Initials**_____

HIPPA NOTICE OF PRIVACY PRACTICES

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgment. **Initials**_____

Signature on File

I have read, gained understanding of, and agree with the above policies and procedures. I authorize this signature on all insurance submissions.

Patient/Guardian Signature: _____ ***Date:***_____

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What is your chief complaint? _____

How/when did this problem start? _____

How would you describe your symptoms (please check all)?

	Sharp		Dull		Aching		Hot		Pins/Needles		Tingling
	Burning		Shooting		Throbbing		Cold		Stabbing		Tender
	Nagging		Heaviness								

What increases your pain/symptoms? _____

_____

What decreases your pain/symptoms? _____

_____

Have you had previous or similar episodes of these symptoms? _____

_____

Medical History (please check all that apply)

	AIDS/HIV		Chest Pain		Fatigue		Joint Replacement		Osteoporosis		Smoker
	Allergies		COPD		Fibromyalgia		Kidney Failure		Other		Sweating
	Anemia		Decreased Appetite		Fracture		Metal Implant		Pacemaker		Tingling
	Anxiety		Depression		Headaches		Muscle Cramps		Pregnant		Tuberculosis
	Asthma		Diabetes I		Hearing Loss		Nausea		Rashes		Ulcer
	Blood Clot		Diabetes II		Hepatitis A/B/C		Night Pain		Raynaud's		Vomiting
	Blurred Vision		Double Vision		Hernia		Numbness		Rheumatoid Arthritis		Weakness
	Bowel/Bladder Changes		Emboli		Hyper/Hypo Thyroid		On Dialysis		Seizure		Weight Loss
	Cancer		Epilepsy		IBS		Osteoarthritis		Shortness of Breath		

Past Medical History (Please list and include dates): _____

_____

_____

Past Surgical History (Please list and include dates): _____

_____

Current Medications: _____

_____

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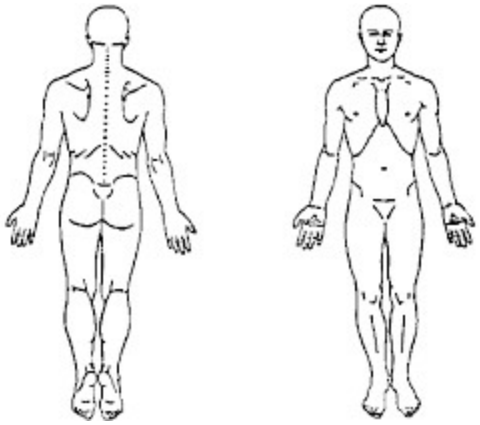
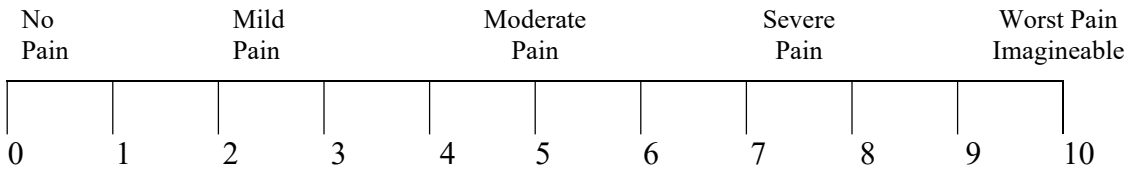
Please circle areas of pain/concern:

Back **Front**



Left Right Right Left

Pain Scale:



What are your goals and expectations for Physical Therapy?

_____

_____

_____

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DIRECT ACCESS LAW - NOTICE OF ADVICE

Beginning in November 2006, New York State Law enacted Direct Access for people to receive physical therapy services without needing a physician prescription or referral.

It is necessary for us to inform you that although the law recognizes your right to have freedom of choice in health care, your health insurance provider may require a prescription or referral in order for the services to be covered. If this is the case, you will be responsible for the fees. Such services may be covered if rendered pursuant to a referral.

You may have physical therapy for **10 visits or 30 calendar days, whichever comes first**. After this time period, a physician's prescription is required. If you do not have a physician, we can assist in finding the best doctor for your current needs.

I affirm that I have read and understand this Notice of Advice:

Patient Name: _____ **Patient/Guardian Signature:** _____

Date of Initial Treatment: _____

Physical Therapist: _____ **Physical Therapist Signature:** _____

CREDIT CARD AUTHORIZATION

Patient Name: _____

Name as it appears on the Credit Card: _____

Payment Method: □ Visa □ MasterCard □ AMEX Card Number: _____

Expiration Date: _____ / _____ (MM/YYYY) Security code: _____

Credit Card Billing Address:

Address: _____ City: _____ State: _____ ZIP :_____

Authorization to Keep Credit Card Number on File (check box below):

The use of keeping your credit card on file is for your convenience. You may elect to provide us with payment information with each visit if you do not wish us to keep your credit card on file.

□ By checking this box**,** I agree to:

1. Authorize OrthoPro Physical Therapy to process the above credit card as "Signature on File" for all services rendered and charges incurred. I understand this authorization will expire upon conclusion of care.
2. Keep this credit card on file and bill all charges to the above credit card.
3. Provide OrthoPro Physical Therapy with written cancellation if, during the course of treatment, I decide to elect out of keeping my credit card on file. Otherwise, I understand that this authorization will expire upon conclusion of care.

Cardholder's Name: _____ **Date:** _____

Cardholder's Signature: _____