First Health Physical Therapy **PATIENT REGISTRATION**

I. Personal Information

Date ______________________ Name (Last, First) ___________________________________

Birthdate _______________ Gender: ☐ Male ☐ Female

F/T Student: _______________ Marital Status ☐ Single ☐ Married ☐ Other

Address ____________________________________ Apt #________ City _______________ State _____ Zip ______

Home Phone __________________________ Work Phone _____________ Extension

Cell Phone ____________________________ Email _________________________

Emergency Contact _____________________ Relationship ___________________________

Home Phone __________________________ Work Phone ____________________ Extension ___________

Referring Doctor _______________________________ Referred By ____________________________________

II. Employment Information

Employer ____ Phone _____________________________

Address ____ City ___________ State _________ Zip _________

III. Insurance Information

Primary Insurance ___________________________

Insurance Company __________________________

Phone ____________________________________

Claims Address _____________________________

City _______________State ____Zip____________

Insured Name ______________________________

Relationship to Patient ______________________

Employer _________________________________

Soc. Sec. Birthdate __________________________

Policy/ Certificate # _________________________

Group # __________________________________

Secondary Insurance ____________________

Insurance Company ______________________

Phone _______________________________

Claims Address ___________________________

City _______________State ____Zip_________

Insured Name ____________________________

Relationship to Patient ____________________

Employer ________________________________

Soc. Sec. Birthdate ________________________

Policy/ Certificate # ______________________

Group # _________________________________

IV. Responsible Party

Name ____ Phone _________________________________

Address ____ City ___________ State _________ Zip _________

V. Practice Policy & Patient Signature

Cancellations: Your appointment time is exclusively for you. It is for this reason that we request you give us **a minimum** of **24 hours' notice** when canceling or you will be charged for the appointment. **The cancellation fee is $125.00**.

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 the patient's insurance companies and other health care practitioner(s) by letter, phone, or fax upon written permission from the patient. Only information necessary to process claims is released to insurance companies.

Patient Consent: 1. I have read and understand the cancellation policy.

2. I authorize the release of any medical information necessary to process all claims, and I authorize First Health Physical Therapy to communicate with my insurance companies and other health care practitioner(s) as necessary by letter, phone, or fax.

3. If assignment is accepted, I authorize and request my insurance companies to pay directly to First Health Physical Therapy benefits 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 claims **if not paid within 45 days, I am responsible for the full amount immediately.**

4. 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.

5. If First Health Physical Therapy is a participating provider with my insurance companies, I understand that I am subject to the terms and conditions of my insurance policy.

Signature ____ Date ______________________________

☐ Private ☐ W.C **OFFICE USE ONLY** Provider ____________________

☐ Medicare ☐ NF DX ______________ Location _____________________

☐ Bill ins ☐ Participating ________ Copay/ Coin ______________ Notes ______________________

☐ Other __________ ______________

FIRST HEALTH PHYSICAL THERAPY

STATEMENT OF FINANCIAL RESPONSIBILITY

Patient Name: ____

First Health Physical Therapy appreciates the confidence you have shown in choosing us to provide your rehabilitation needs. The service you have elected to participate in implies a financial responsibility on your part. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. You are responsible for any copay, percentage or deductible as determined by your contract with your insurance carrier. Ultimately, you are responsible for any amount not covered by your insurance company.

Your insurance information was verified as the following:

Copay of $ _______/ per visit
Insurance will cover _______ % Patient responsibility _______ %
Deductible per year $ ______ $ ______ has been met
Out of pocket $ _______ $ ______ has been met

I have read the above information regarding my insurance policy. I certify that the information above, to the best of my knowledge, is true and accurate. I authorize my insurance carrier to pay First Health Physical Therapy directly for services provided. I agree to pay First Health Physical Therapy the entire amount of bills incurred for physical therapy services provided not covered by my insurance carrier.

Signature ____ **Date:** __________________
(If other than patient; Relationship to patient: _________________________________**)**

CONSENT OF TREATMENT & AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize First Health Physical Therapy through its appropriate personnel to perform, or have performed upon me, or the above named patient appropriate assessment and treatment procedures relating to the diagnosis stated by my referring physician.

I further authorize First Health Physical Therapy to release to the appropriate agencies, any information acquired in the course of my, or the above named patient's, examination and treatment.

Signature ____ **Date:** __________________
(If other than patient; Relationship to patient: _________________________________**)**

FIRST HEALTH PHYSICAL THERAPY

119W. 57th Street, Suite 212
New York, NY 10019
Tel: (212) 421-1740 | Fax: (212) 421-1750

NOTICE OF PRIVACY AND PRACTICES
As required by the Privacy Regulations of the Health
Insurance Portability and Accountability Act (HIPAA)
EFFECTIVE DATE: APRIL 14, 2003

I have been informed of the regulations regarding the Patient Health Information Notice of Privacy and Practices by First Health Physical Therapy.

____
Patient Name (Print)

____
Signature of Patient/ Guardian

____
Date

FIRST HEALTH PHYSICAL THERAPY

Medical History Form

1. Please mark the appropriate boxes that apply to your medical history:

☐ Diabetes ☐ Hypertension ☐ Cancer ☐ Heart Disease ☐ Stroke
☐ Asthma ☐ Heart Attack ☐ Emphysema ☐ Tuberculosis ☐ Angina
☐ Hepatitis ☐ Osteoarthritis ☐ Pacemaker ☐ Epilepsy ☐ Pregnant
☐ Allergies ☐ Alcohol abuse ☐ Depression ☐ Tobacco Use ☐ Drug Abuse
☐ Cardiovascular Disease ☐ Rheumatoid Arthritis

2. Please list any other diseases or condition you have not mentioned above:

3. Please list any previous surgeries or hospitalizations:

4. Please list any medications you are currently taking. Please include the dosages:

5. Please list any recreational activities you are currently involved in:

6. Please rate your pain at rest: (0 = None) 0 1 2 3 4 5 6 7 8 9 10 (10 = Unbearable)

7. Please rate your pain with movement: (0 = None) 0 1 2 3 4 5 6 7 8 9 10 (10 = Unbearable)

8. Please circle the items that best describe your symptoms:

Sharp **Dull** **Throbbing** **Numbness** **Tingling** **Burning** **Shooting** **Radiating**

9. Please indicate where your pain is located:

10. Height ____ ft ____ in

11. Weight _____ lbs

12. Blood pressure: _______ systolic

_______ diastolic

NAME: ______________________________

QuickDASH - Initial Patient name:_______________________________________ Date:__________

INSTRUCTIONS

This questionnaire asks about your symptoms as well as your ability to perform certain activities.
Please answer every question, based on your condition in the last week, by circling the appropriate number.
If you did not have the opportunity to perform an activity in the past week, please make your best estimate of which response would be the most accurate.
It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

1. Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand(e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups?	1	2	3	4	5
	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5
Please rate the severity of the following symptoms in the last week. (circle number)	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
	NONE	MILD	MODERATE	SEVERE DIFFICULTY	SO MUCH DIFFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? (circle number)	1	2	3	4	5

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Therapist Use Only

Comorbidities:
☐Cancer
☐Diabetes
☐Heart Condition
☐High Blood Pressure
☐Multiple Treatment Areas
☐Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI)
☐Obesity
☐Surgery for this Problem
☐Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)

ICD9 Code: