body align
physical therapy, p.c.

Patient Express Registration

Todays Date:

1. Personal Info

Please Fill-Out Entire Form Completely & Legibly.

Last Name _____ First Name _____ Age _____ ❑ Male ❑ Female

Street Address _____ City _____ State _____ ZIP _____

(_____) Home Phone _____ (_____) Cellular _____ Email Address (Important) _____

Emergency Contact Person _____ (_____) Phone # _____ (if minor) Parent/Guardian Name and Signature _____

Occupation _____ Employer Name _____ (_____) Phone # _____

- My condition is related to: ❑ Work ❑ Auto Accident (State_____) ❑ Other_____

Social Security #_____ Date of Birth_____/_____/_____ ❑ Single ❑ Married

Work Status: ❑ Currently Employed: ❑ Retired ❑ Disabled (__Total or __Temporary) ❑ Student (__P/T __F/T)

2. Referral Info

ALL INFO REQUIRED

How did you hear about us? _____

If by a friend or family member, please give their phone number and address below that we may send a thank you note and small gift.

_____

_____

Primary or Referring Physician Name _____

Street Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Email Address _____

Do you have a followup appointment with this physician?_____

If yes, when? _____

3. Insurance Info

Patient Name _____ DOB _____

ID # _____

Insurance Policy # _____ Group # _____

Insured Name (if other than patient) _____ Insured DOB _____

Your relationship with the Insured:

❑ Parent ❑ Spouse ❑ Other: _____

2. Credit Card on File

Safe and Secure. I understand I will be notified of any and all charges prior to processing.

__Visa __MC __Discover Card #_____

Name on Card_____ Exp Date_____ CVV code_____

❑ I have read and agree to all the policies on the back of this form. Signed_____

Important Company Policies for a Successful Relationship

We strive to provide you the best personalized care available. To make this possible we adhere to a set of very important guidelines. Please read them carefully, initial all the boxes, and indicate your agreement by signing the bottom.

Initial All Boxes ☐ **Late cancellations**
If you wish to change or cancel an appointment, we require a minimum of 24 hours advanced notice. Anything less will result in a $50 fee. This allows someone else to reserve a spot on the schedule so please be courteous and responsible.

☐ **Copayments** are due at each treatment session.

☐ **No-shows**: If you fail to show up for a scheduled appointment without notice, all future appointments will be removed and a $50 fee will be charged.

☐ **Cell phones** must be silenced.
We realize emergencies may arise. Please be respectful to other patients and your therapist when using your phone.

☐ There is no **daycare** for babies or children. Patients are encouraged to arrange for child care prior to their physical therapy session. We don't want your children to get hurt on the gym equipment.

☐ As a courtesy to you, we will submit all your insurance claims and the necessary documentation in a timely manner. **If your insurance company fails to pay or doesn't meet our minimum reimbursement, you will be responsible for the balance.**

☐ **Financial hardship**: If you are experiencing financial difficulties and are unable to afford the cost of our services, we have a "Financial Hardship Form" which may be filled out. If you qualify for financial assistance according to the federal guidelines, we will waive or discount your portions of the bill. Ask Vanessa or Jill for assistance.

We look forward to helping you!

Patient Name: _____

Signature: _____ Date: _____

Physical Therapy Pre-Exam Questionnaire

In Order to evaluate your condition fully, please be as accurate as possible. Thank you.

1. What is your age? _____
2. What is your gender? ☐ Male ☐ Female
3. What is your occupation? _____
   -Are you working now? ☐ Yes ☐ No
4. Have you had physical therapy before? ☐ Yes ☐ No
5. Where is your pain/problem? _____
6. What caused your pain/problem? _____
7. Approximately when did it start? ___ / ___ / 20___
8. Is it getting worse, better, or staying the same? ☐ Worse ☐ Better ☐ Same
9. Have you ever had this pain/problem before? ☐ Yes ☐ No
10. On the scale below <u>circle</u> your worst pain level in the past couple days?

    Mild *Moderate* *Severe*
    0….1….2….3….4….5….6….7….8….9….10
11. Please list all medications you are currently taking:

12. Are any of your usual everyday activities affected? ☐ Yes ☐ No
    - If yes, describe how:

13. List all past surgeries with dates:

14. List all medical conditions you have (or were told you have):

Patient Name: _____

Signature: _____ Date: _____

Assignment of Benefits to Body Align Physical Therapy, PC

Patient Name: _____ DOB: _____ ID#: _____

Insurance Policy #: _____

Insurance Name: _____ Insured Date of Birth: _____

Your relationship to the Insured: ☐ Parent ☐ Spouse ☐ Other: _____

Claim#: _____

I hereby instruct and direct _____ insurance company to pay by check made out and mailed to:

Body Align Physical Therapy, PC
32 Union Square East, 7th Floor
New York, NY 10003
535-328-2525

If my current policy prohibits direct payment to Body Align Physical Therapy, I hereby also instruct and direct you to make out the check to me. Please mail it to the above address for the medical treatments I received. Otherwise make it payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

This is a direct assignment of my rights and benefits under this policy.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

(Check each box and sign at the bottom)

- ☐ A photocopy of this Assignment shall be considered as effective and valid as the original.
- ☐ I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or atorney involved in this case for the purpose of processing claims and securing payment of benefits.
- ☐ I authorize the use of this signature on all insurance submissions.
- ☐ I authorize Body Align Physical Therapy, PC to deposit checks made in my name.
- ☐ I authorize Body Align Physical Therapy, PC to initiate a complaint to the Insurance Commisioner for any reason on my behalf.
- ☐ I understand that I am financially responsible for all charges whether or not paid by insurance.

Dated this _____ day of _____ , 20 _____ .

Signature of Policyholder: _____ Witness: _____

Signature of Claimant, if other than Policyholder: _____

Body Align Physical Therapy, PC

Statement of Privacy Notice

Effective June 1, 2003

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

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

We may disclose your health information to coroners or medical examiners.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

We may contact you by phone, mail, or email. "It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity.

In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by us.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us by calling this office at (951) 279-0777. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints about your Privacy rights, or how we have handled your health information should be directed to our Privacy Officer by calling this office at (951) 279-0777. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Body Align Physical Therapy, PC with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

_____
Patient's Name (print)

_____
Patient's Signature Date

_____
Authorized Facility Signature Date