PERFECT STRIDE
PHYSICAL THERAPY

Patient Registration

Admit Date Account #	Facility Name / Facility #	Intake Completed By
First Name, Middle Initial	Last Name	Marital Status: D M S W
Street Address	City	Zip Code
Date of Birth		Male Female
Home Phone	Work or School Phone	Cell Phone
Email Address	**Text Message Appointment Reminders Yes____ No_____**	Body Part
Referring Doctor Next Doctor Appt _____	Surgery Yes ___ No ___ Surgery Date _____	Surgical Procedure _____
Is this injury due to a Worker Comp or MVA?	Date of Injury	State

☐ ***I would like to receive the Perfect Stride Physical Therapy Newsletter email which will include wellness information, staff & facility changes, updates, etc. (The option to unsubscribe will always be available)***

Primary Insurance Company Name		
Insurance Company Street Address	Insurance Company City, State, Zip Code	Insurance Company Phone Number
Name of Insurance Policy Holder		Insured's Date of Birth
Insured's Policy Number	Insured's Group Number	Relationship to Insured
Insured's Employer	Employer Street Address	Employer City, State, Zip Code
Employment Status:	FT PT Retired Not Employed	Self Employed Active Military
Secondary Insurance Company Name and Address		
Insurance Company Phone Number	Name of Insurance Policy Holder	Relationship to Insured
Insured's Social Security Number	Insured's Date of Birth	Insured's Policy Number / Group Number
Have you received physical therapy, occupational therapy, or chiropractic services in the past year? Yes ___ No ___		How many visits?
Have you had home health care prior to physical therapy? Yes ___ No ___	Do you have an attorney for this injury? Yes ___ No ___	Is there a case manager assigned? Yes ___ No ___
Case Manager Name	Case Manager Phone Number	

Patient Signature _____ ***Date*** _____

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Patient Medical History

Name: _____ Referring Doctor: _____

Occupation: _____ Injured Body Part: _____

Have you had previous PT for this injury? Yes ___ No ___ **Have you had surgery for this injury? Yes ___ No ___**

If yes, when?_____ Type/Date of Surgery: _____

Is this injury the result of a work or car accident? Yes ___ No ___ Right-Handed ____ Left-Handed ____

PLEASE LIST THE TYPE AND DOSAGE OF ALL prescription **and** over the counter medications, herbals, vitamins, minerals, or nutritional (dietary) supplements that you are currently taking:

___ Please check if separate medicate / dosage list is attached

Type	Dosage	Type	Dosage
Type	Dosage	Type	Dosage

Please CHECK any of the following whose care you are under:

___ General Practitioner ___ Osteopath ___ Neurologist ___ Chiropractor

___ Physical Therapist ___ Orthopedist ___ Psychiatrist / Psychologist ___ Other (Please specify)

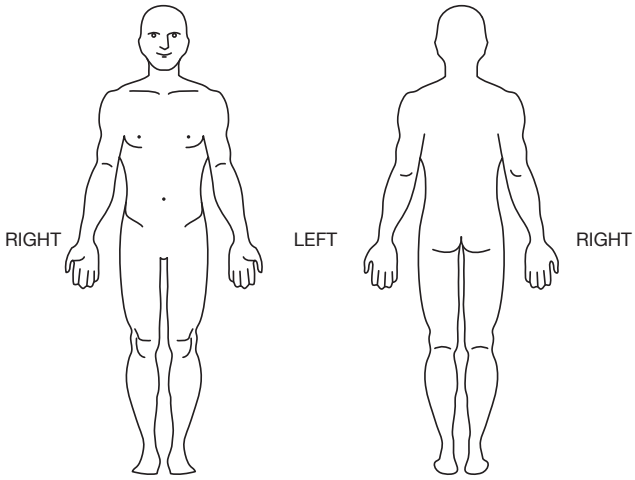
If you have seen any of the above during the past 3 months, please describe for what reasons (illness, medical condition, physical, etc):

_____

PAIN DIAGRAM

Mark these drawings according to where you are hurt or feel pain. For example, if the right side of your neck hurts, mark the drawing on the right side of the neck. Please indicate which sensations you feel by referring to the key below.

////	STABBING
XXXX	BURNING
0000	PINS & NEEDLES
====	NUMBNESS
++++	ACHING



Which number best indicates your current pain level: ____	
0	No Pain
1	Mild Pain; you are aware of it, but it doesn't bother you
2	Moderate pain that you can tolerate without medication
3	Moderate pain that requires medication to tolerate
4-5	More severe pain; you begin to feel antisocial
6	Severe pain
7-9	Intensely severe pain
10	Most severe path; Emergency Room Care

EMERGENCY CONTACT NAME AND PHONE: _____

Please check if you have EVER been diagnosed as having any of the following conditions:

___ Cancer
If yes, describe: _____
___ High Blood Pressure
___ Controlled by Medication? ___ Yes ___ No
___ Heart Problems
Type:_____
___ Diabetes
Controlled by: ___ Diet ___ Medication ___ Exercise ___ Not controlled
___ Circulation Problems
___ Asthma
Type: _____

___ Chemical Dependency (ie: alcoholism)
___ Thyroid Problem
___ Stroke
___ Multiple Sclerosis
___ Rheumatoid Arthritis
___ Weight Loss / Energy Loss
___ Severe / Frequent Headaches
___ Kidney Disease
___ Anemia
___ Epilepsy / Seizures
___ Tuberculosis

___ Hepatitis
___ Depression
___ Osteoporosis
___ Hernia
___ Joint Replacement
Type / Date:_____
___ Vision / Hearing Difficulties
___ Other Arthritic Conditions
___ Are you pregnant?
___ Do you have allergies?
Describe: _____

How much caffeinated coffee or caffeine-containing beverages do you drink per a day? _____
How many days per week do you drink alcohol? _____
How many packs of cigarettes do you smoke per day? _____
How many alcoholic drinks per day? _____

Have you recently noted:

___ Excessive Weight Loss / Gain ___ Nausea / Vomiting ___ Fatigue ___ Weakness ___ Fever / Chills / Sweats ___ Numbness or Tingling

Please list any sport or leisure activities you participate in: _____

Patient Signature _____ ***Date*** _____

PERFECT STRIDE
PHYSICAL THERAPY

Notice of Privacy Practices

At Perfect Stride Physical Therapy, PLLC, we are dedicated to providing top quality service and physical rehabilitation treatment. Protecting your privacy is of paramount importance to us, and we have implemented procedures to safeguard the information included in your files.

This notice describes how Protected Health Information (PHI) about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Personal and Protected Health Information

- We may gather personal health information from you, other health care providers and third party payers. This information is used for treatment, payment and health care operations. The following describes the ways we may use and disclose your Protected Health Information:

- We may provide PHI about you to health care providers, other practice personnel, or third parties who are involved in the provision, management or coordination of your treatment care
- We may disclose your PHI to any third party that you designate in writing
- We may use or disclose your PHI so that we can collect or make payment for the health care services you receive or are going to receive

- We may disclose your PHI if we believe that it is necessary to prevent a serious threat to your health and safety or the health and safety of the public
- We may disclose your PHI to a government agency if we believe you have been a victim of abuse, neglect, or domestic violence. We will make this disclosure if it is necessary to prevent serious harm to you or other potential victims, you are unable to agree due to your incapacity, you agree to the disclosure, or required by law
- We may disclose your PHI to a health oversight agency for activities authorized by law
- We may disclose your PHI as required by a court of administrative order, or under certain circumstances in response to a subpoena, discovery request or other legal process
- We may release your PHI as necessary to comply with laws relating to Workers' Compensation or similar programs that are established by the law to provide benefits for work-related injuries or illness without regard to fault
- Your PHI may be disclosed for military and veterans affairs, for national security and intelligence activities, or for correctional activities
- We may use or disclose your PHI when required by law
- We may use your name, address, phone number, e-mail, and your records to contact you with appointment reminder calls, recall postcards, greeting cards, information about physical rehabilitation, or other related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine

Please note your rights regarding this information:

1. You are entitled to inspect and receive copies of your records upon written request
2. You are entitled to make a written request to amend your PHI files or put restrictions on certain uses and disclosure of PHI
3. We accommodate any reasonable request, yet we retain the right to deny inclusion of amendments or use restrictions of your PHI
4. You have a right to receive all notices in writing
5. You have the right to request that we do not disclose your information to specific individuals, companies, or organizations. Any restrictions should be requested in writing. We are not required to honor these requests. If we agree with your restrictions, the restriction is binding on us

If you have questions regarding your HIPAA Privacy rights, please call Perfect Stride Physical Therapy at (917) 494-4284 or email Daniel Park at parkd13@gmail.com

This notice remains in effect until it is replaced or amended by changes in the law.

Patient Signature _____ ***Date*** _____

PERFECT STRIDE
PHYSICAL THERAPY

Attendance Policy

[For office use only]
Office Cancellation Fee $ __100___

Patient Attendance Policy Agreement:

Perfect Stride Physical Therapy of New York strives to provide each patient with the highest quality of care while attempting to accommodate your schedule to your convenience. Therefore, we provide reserved time slots for each patient with a specific therapist in order to minimize waiting times and assure continuity of your personal treatment. Your consistent attendance of the planned treatment regimen is paramount to your full recovery.

Cancellations, especially last minute ones, along with patient no-shows, decrease our ability to accommodate the scheduling needs of other patients. We must ask for your full cooperation with the following policy:

- If you are unable to keep a scheduled appointment, we request that you notify our office 24 hours prior to your scheduled appointment time. If someone is not available to take your call, please leave a message on our answering system.
- All cancellations and no-shows will be documented in our medical records and appropriately reported to your physician and insurance/ third party payer.
- If you accumulate 2 cancellations or no-shows, your therapist may refer you back to your physician before scheduling another appointment or may choose to discharge you from therapy and report this to your physician.
- **If you do not honor a scheduled appointment either by late cancellation or no show, then you will be charged a fee, due upon your next scheduled visit.**

We believe that this policy is necessary for the benefits of all patients, so that we can continue to provide high quality treatment and service to everyone.
All Perfect Stride Physical Therapy staff and patients appreciate your cooperation and adherence to this policy.

Patient Signature _____ ***Date*** _____

Please indicate the ~~primary~~ reason you chose to come to Perfect Stride PT.

☐ My doctor specifically recommended Perfect Stride PT MD Name:

_____

☐ I chose Perfect Stride PT from a list my MD provided me

☐ I am a previous Perfect Stride PT patient

☐ A family member, friend or co-worker recommended Perfect Stride PT Name:

_____

☐ My Case Manager recommended Perfect Stride PT Case Manager Name:

_____

☐ On-line search led me to Perfect Stride PT website Which search engine did you use? Google, Yahoo, Bing, Other: _____

☐ Social Media Channels: Facebook / Twitter / Perfect Stride PT Blog (Please Circle One) Other:

☐ _____

PERFECT STRIDE
PHYSICAL THERAPY

Informed Consent

Perfect Stride Physical Therapy, PLLC

Please read this document carefully and sign where indicated

You are the most important person on your health-care team and, as such, are entitled to receive clear and comprehensive information about the modalities, techniques, and duration of your therapy. Becoming informed and understanding what to expect from your treatment from the beginning will help make your experience more comfortable and, we believe, more effective overall. If you have any questions about your health, your treatment, or any aspect of your physical therapy, please feel free to discuss your concerns with your physical therapist.

Informed Consent/Financial Responsibility

_____ *[initials]* I, the undersigned, hereby give my consent for Perfect Stride Physical Therapy, PLLC to furnish medical care an treatment consid-ered necessary to diagnose and treat _____ *[name of patient]*. I acknowledge that interns, physical therapy students, and other health care professional students may take part in patient care under the supervision of licensed physical therapists and as a part of their education and training . I recognize that treatment results may vary and that no assurance of guaranty had been made by anyone regarding the outcome of my treatment.

Benefit Assignment/Release of Information

_____ *[initials]* I hereby assign Perfect Stride Physical Therapy, PLLC, all medical and insurance benefits to which I am entitled to, including health plan benefits. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize you to release all medical informa-tion necessary to my health care provider/s and insurance company to obtain payment.
Important Information About Your Privacy Rights: Perfect Stride Physical Therapy, PLLC, will use and disclose your personal health information only for treatment, payment and to conduct healthcare operations related to your care. We also have a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies regarding personal health information. By signing below, you acknowledge that you have received a copy of this NOTICE OF PRIVACY PRACTICES.

Financial Policy Statement

_____ *[initials]* I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by representatives of Perfect Stride Physical Therapy, PLLC. I understand that my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand I am responsible for fees not paid in full, co-payments, and policy deductibles and coinsurance except where my liability is limited by contract or State or Federal law. (Not Applicable to Worker' Compensation Patients)

ut of Network Acknowledgment

initials I acknowledge that I am aware that Perfect Stride Physical Therapy is an ut of Network provider with my insurance policy, and benefits uoted to me are based on the out of network coverage of my plan.

Estimated Insurance Benefits:

Insurance/s: _____ (2) _____

Benefits: (1) _____

(2) _____

Estimated Patient Payment: _____ At time of Service

Note: Payment is due at time of service

I have read and understand this document. Any questions that I have were answered to my satisfaction.

_____ _____

Patient Name (print) [initials] PSPT Representative

_____ _____

Signature of Patient Date