PATIENT DATA SHEET (1)

Patient Information

Patient's Name _____

LAST FIRST MI

Address _____

City _____ State _____ Zip Code _____

DOB _____ / _____ / _____ SS# _____ - _____ - _____

Home Phone _____ Cell Phone _____

Email Address _____

Would you like to receive an email confirmation of your appointments? ◯ YES ◯ NO

Emergency Contact Name _____

Emergency Contact Phone _____ Relationship _____

How did you hear about ProMet Physical Therapy, PC? _____

Policy Holder Information (if other than self)

Relationship to patient ◯ Spouse ◯ Parent ◯ Other

Name _____ DOB _____/_____/_____

Address _____

City _____ State _____ Zip Code _____

Home/Work/Cell _____ SS# _____ - _____ - _____

Primary Insurance Information

Carrier Name _____

Policy # _____ Policy Holder_____

ID # / Claim # _____

Secondary Insurance Information

Carrier Name _____

Policy # _____ Policy Holder_____

ID # / Claim # _____

PATIENT DATA SHEET (2)

Injury/Condition Information

Injury/Condition _____

Is this injury the result of an accident? ◯YES ◯NO

If "YES," is the accident: ◯WORK ◯AUTO ◯SLIP&FALL

Did you have surgery for this injury/condition? ◯YES ◯NO

If yes, please provide the date of surgery _____/_____/_____

Referring Physician _____

Physician Phone _____

Have you had physical therapy for this condition this year? ◯YES ◯NO

If yes, how many visits? _____

Have you had physical therapy at all this year? ◯YES ◯NO

If yes, how many visits? _____

Medicare Patients Only

Have you had physical therapy this year? ◯YES ◯NO

If yes, how many visits? _____

Have you had home care this year? ◯YES ◯NO

If yes, provide date of your last visit? _____

Are you currently receiving home care? ◯YES ◯NO

Student Athletes Only

What sport(s) do you participate in? _____

Were you injured at school or outside league? _____

Was the proper paperwork filed at school/outside league? ◯YES ◯NO

MEDICAL HISTORY

Are you currently taking any prescription or non-prescription medications? ○ YES ◉ NO

Anti-Inflammatory ◉ NO ○ YES _____

Muscle Relaxers ◉ NO ○ YES _____

Pain Medication ◉ NO ○ YES _____

Other ◉ NO ○ YES _____

Have you had any of the following medical or rehabilitative services for this injury? (Circle all that apply)

- ☐ Chiropractor
- ☐ General Practitioner
- ☐ Massage Therapy
- ☐ Neurologist
- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Podiatrist
- ☐ CT Scan
- ☐ EMG/NCV
- ☐ Emergency Room Care
- ☐ Injection(s)
- ☐ MRI
- ☐ Myelogram
- ☐ X-Rays

Do you have or ever had any of the following? (Circle all that apply)

- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis/Swollen Joints
- ☐ Asthma/Bronchitis/Emphysema
- ☐ Blood Clots
- ☐ Bowel or Bladder Problems
- ☐ Cancer/Chemotherapy/Radiation
- ☐ Coronary Heart Disease or Angina
- ☐ Diabetes
- ☐ Dizziness or Fainting
- ☐ Emotional/Psychological Problem
- ☐ Epilepsy/Seizures
- ☐ Gout
- ☐ Heart Attack or Surgery
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ Infectious Disease
- ☐ Joint Replacement
- ☐ Numbness or Tingling
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Severe Headaches
- ☐ Shortness of Breath
- ☐ Stroke/TIA
- ☐ Thyroid Trouble/Goiter
- ☐ Varicose Veins
- ☐ Vision or Hearing Difficulties
- ☐ Weakness
- ☐ Weight Loss/Energy Loss
- ☐ Ankle Injury/Surgery
- ☐ Back Injury/Surgery
- ☐ Elbow/Hand/Injury/Surgery
- ☐ Knee Injury/Surgery
- ☐ Pins or Metal Implants
- ☐ Pregnant

Do you smoke? ○ YES ○ NO

Do you drink? ○ YES ○ NO

Are you allergic to latex? ○ YES ○ NO

CONSENT FOR TREATMENT/ASSIGNMENT OF BENEFITS

I, the undersigned, a patient of ***ProMet Physical Therapy, PC*** (here-on referred to as ProMet PT), do hereby authorize ProMet PT to administer treatment as necessary. I understand that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that, as a courtesy, ProMet PT will prepare insurance forms and bill my insurance carrier directly. I hereby request assignment of payment of all insurance benefits to ProMet Physical Therapy, PC. I am ultimately responsible for payment of all services rendered, unless otherwise provided by the law.

DEDUCTIBLES/PERCENTAGE PAYS AND/OR CO-PAYMENTS

All applicable deductibles and co-payments as determined by my health plan are to be paid at time of service. No exceptions. Co-Insurance balances will be billed at the time of receipt of payment from my insurance carrier. Payment is due within 30 days of the date on the invoice. I, the patient, am to keep all payments current. Payment may be made by cash, credit or check. I understand that a fee of **$25** will apply to each bounced/returned check.

Co-Payment Amount $ _____ per visit **Patient Initials _____**

Deductible Amount $ _____ due at 1st visit **Patient Initials _____**
THEN $ _____ per visit for ___ visits

Co-Insurance Amount _____% of allowable amount **Patient Initials _____**
due upon receipt of EOB

CANCELLATION/NO-SHOW POLICY

I understand that cancellations should be made within 24 hours from the time of my scheduled appointment, unless extenuating circumstances prevent me from doing so. I understand that a **$25** cancellation/no-show fee will apply any time I fail to cancel my appointment within 24 hours or if I do not show to a scheduled appointment.

Patient Initials _____

By signing below, I agree to all the above terms and conditions. Additionally, I confirm that I have received a copy of ProMet Physical Therapy, PC's Notice of Privacy Policy.

Patient or Parent/Legal Guardian Signature Date

Printed Name of Patient or Parent/Legal Guardian

71-19 80th Street, Ste 8210, Glendale, NY 11385 Phone: (718) 554-6610 Fax: (718) 360-4908
123-08 Metropolitan Ave, Kew Gardens, NY 11415 Phone: (718) 880-2385 Fax: (718) 880-2386
Email: info@prometpt.com Web: www.prometpt.com

ProMet Physical Therapy, PC's Privacy Policy

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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical and dental records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

<u>Uses and Disclosures of Protected Health Information</u>

Your Protected Health Information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the practice, and any other use required by law.

Treatment: We will use and disclose your Protected Health Information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the health care professional has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, and conducting or arranging for other business activities. We may use or disclose, as needed, your protected health information to support the business activities of this practice. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may call your home and leave a message (either on an answering machine or with the person answering the phone) to remind you of an upcoming appointment, the need to schedule a new appointment or to call our office. We may also mail a postcard reminder to your home address. If you would prefer that we call or contact you at another telephone number or location, please let us know.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal

Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of HIPAA.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

The Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in you care or for notification purposes described in this Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply. Your physician is not required to agree to a restriction you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this Notice from us, upon request, even if you have agreed to accept this Notice alternatively (i.e. electronically).

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this Notice and will inform you of any changes. You then have the right to object or withdraw as provided in this Notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer of your complaint at our office and main telephone number. **We will not retaliate against you for filing a complaint.**

This Notice was published and becomes effective on/or before 11/05/2007.

ProMet Physical Therapy, PC
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Glendale, NY 11385

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123-08 Metropolitan Avenue
Kew Gardens, NY 11415