DOWNTOWN
PHYSICAL THERAPISTS NYC

PATIENT INFORMATION FORM:

Last Name:_____ First Name: _____MI:_____

Address:_____ Apt_____

City:_____ State:_____ Zip Code:_____

Contact's#: Home (____) _____ Cell (____) _____

Tel. Other (____) _____ Email _____

Date of Birth:_____/_____/_____ SSN:_____ Sex: [_] Male [_] Female

Marital Status: - [_] Single - [_] Married - [_] Widowed - [_] Separated - [_] Divorced

Referring Physician: _____ Tel#: (____)_____

Employer's Name & Address:_____ Tel#: (____)_____

How did you hear about us?: Radio_____ AD_____Word of Mouth____ TV_____ Yellow Pages_____ ZocDoc _____

IN CASE OF EMERGENCY: Name:_____ Relationship:_____Tel#: (____)_____

PRIMARY INSURANCE

Insurance Name:_____ Policy#:_____ Group#:_____

Insurance Address:_____ Tel#: (____)_____

Subscriber Name:_____ DOB: _____/_____/_____ SSN:_____

Address:_____ City:_____ State:_____

Zip Code:_____ Tel#: (_____)_____

Relationship to Insured: [_] Self [_] Spouse [_] Child/Dependent [_] Other:_____

SECONDARY INSURANCE

Insurance Name:_____ Policy#:_____ Group#:_____

Insurance Address:_____ Tel#: (____)_____

Subscriber Name:_____ DOB: _____/_____/_____ SSN:_____

Address:_____ City:_____ State:_____

Zip Code:_____ Tel#: (_____)_____

Relationship to Insured: [_] Self [_] Spouse [_] Child/Dependent [_] Other:_____

PHARMACY INFORMATION

Pharmacy Name: _____ Telephone Number:_____

I understand and agree that (regardless of my insurance status) I am responsible for the balance on my account for any professional services rendered. I have all the information on this sheet and have and completed the above answers. I certify that this information is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in the place of the original. I request payment from my insurance company made directly to Physical Therapists NYC (when they accept assignment). If the insurance check is mailed to me instead of Physical Therapists NYC. I will forward the check within one week or be charged interest. I certify that the above information I have reported is correct.

SIGNATURE:_____ DATE:_____

DOWNTOWN
PHYSICAL THERAPISTS NYC

Chart No._____

Name:_____

GENERAL CONSENT FOR TREATMENT

For patients seeking in-patient, out-patient and/or emergency room services.

1. I am asking for medical care and treatment at this facility and agree to accept services which may diagnose a medical condition, procedures to treat my condition and routine dental and medical care. I understand that these services will be provided to me by physicians, dentists, nurse practitioners, midwives, physician assistants and other health care providers, some of whom may be in training. I have not been given any guarantees as to the results of the service I will receive.
2. I understand that my agreement to accept these services will remain in effect unless I say that I no longer want these services or until my treatment is completed.
3. I understand that my agreement to accept these services is called a General Consent and that it includes any routine procedure(s) or treatment(s) such as blood drawing, physical examination, administration of medication(s), taking x-rays, use of local anesthesia and other non-invasive procedures.

_____ _____
Signature of Patient or Parent/ Legal Guardian of Minor Patient Date

If the patient cannot consent for him/herself, the signing of either the health care agent or legal guardian who is acting on behalf of the patient, or the patient's next of kin who is assenting to the treatment for the patient, must be obtained.

_____ _____
Signature of Health Care Agent/Court Appointed Guardian Date
(Place copy of the authorizing document in the medical record)

_____ _____
Signature & Relationship of Next of Kin Date

WITNESS:

I,_____ am a facility employee who is not the patient's health care provider and I have witnessed the patient or other appropriate person voluntarily sign this form.

_____ _____
Signature & Title of Witness Date

INTERPRETER/ TRANSLATOR:
(To be signed by the interpreter/ translator if the patient required such assistance.)

To the best of my knowledge the patient understood what was interpreted/ translated and voluntarily signed this form.

_____ _____
Signature of Interpreter/ Translator Date

PHYSICAL THERAPISTS NYC

ACKNOWLEDGEMENT FORM

Notice of Privacy Practices

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

SUMMARY:
By law, we are required to provide you with our Notice of Privacy Practices (NPP). The Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following right:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communication;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of the Notice.

We want to assure you that your medical/protected health information is secure with us. The Notice contains information about how we will insure that your information remains private.

If you have any questions about the Notice, the name and phone number of our contact person is listed on the last page of the **NOTICE OF PRIVACY PRACTICE** form.

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of this practice's **NOTICE OF PRIVACY PRACTICE** form. I further understand that the practice will offer me updates to the **NOTICE OF PRIVACY PRACTICES** should it be amended, modified, or changed in any way.

_____
Patient or Representative Name (Please Print)

_____ _____
Patient or Representative Signature Date

[_] Patient refused to sign [_] Patient

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**