NEW YORK
HAND & PHYSICAL THERAPY

Patrick Clough PT, CHT - Director

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Phone: 845-632-6775 Fax: 845-632-6777 www.newyorkhand.com

Name: _____

Gender: ____ Male ____ Female Social Security _____

Date of Birth: _____ / _____ / _____

Address: _____

_____

Primary phone number: _____ (circle one) home / cell / work / other

Secondary phone number: _____ (circle one) home / cell / work / other

Email address: _____

Preferred contact method of confirmations (please circle): Call to primary # / Text to cell # / Email

Employer Information:

Name: _____

Address: _____

Phone # _____

Problem Description: _____

Referred by: _____

In case of emergency whom should we contact:

Name: _____

Relationship: _____ Phone# _____

I authorize the release of information requested by my insurance plan for payment. I understand that I am financially responsible for any balance due including an applicable co-payments or deductibles as decided by my insurance. I agree to comply with the terms and conditions as outlined in this paperwork. I hereby acknowledge that I have been familiarized with the Notice of Privacy Policy

Name: _____ Date: _____

Primary Insurance Information

(please fill out even if you are under No Fault or Workman's Compensation)

Patient's name as on insurance card: _____

Insurance company: _____

Member ID #: _____ Group # (if applicable): _____

Co Pay: _____ Deductible/Coinsurance: _____

Subscriber Information:

Name: _____

Relationship: _____ Date of Birth: _____

Secondary Insurance Information:

Patient's name as on insurance card: _____

Insurance company: _____

Member ID # _____ Group # (if applicable): _____

Co Pay: _____ Deductible/Coinsurance: _____

Subscriber Information:

Name: _____

Relationship: _____ Date of Birth: _____

NO FAULT (NF)/ WORKERS COMPENSATION (WC) INFORMATION

What kind of claim will this be under (circle one): WC NF

Insurance company: _____

Policy #: _____

Claim #: _____

Date of accident/incident: _____

Insurance adjuster name & phone # _____

Insurance subscriber (if other than self):

Name: _____

Date of Birth: _____ Phone # _____

Address: _____

• Be sure to fill out the NF or WC assignment of benefits form as well *

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To our valued patient,

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that we continually undergo training so that we may understand and comply with government rules and regulations regarding, the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standard of ethics and integrity when performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance of the governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI.

Notice of Privacy

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health information (PHI) is protected for privacy reasons. The Privacy Rule provides standards for health care providers to follow, when disclosing patient health information, that is needed to carry out proper treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. When it is necessary, we provide the minimum amount of information only to those we feel are in need of your health care information as we strive to provide the best health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. If you want to request restrictions pertaining to parties you do no what PHI released to, please inform our staff and it will be documented in your chart. If you have any further questions about the privacy of your medical records or our general policies please let our staff know. Thank you very much.

Patient Name (please print): _____

Patient Signature: _____ Date: _____

If minor, parent/guardian signature: _____

MISSED APPOINTMENT FEES

We understand that circumstances arise that do not allow you to keep your appointments, however please be courteous to us and our other patients by giving us notice 24 hours prior to your appointment. Many other offices choose to overbook their schedule to make up for missed appointments, which can lead to long wait times. We do not do this, therefore we will promise to limit your wait time by not overbooking, but we will count on you to be at your appointments. Please note: that if you are more than 15 minutes late we may be forced to reschedule your appointment or you may choose to wait for the next available slot for that day.

FEES: For each missed appointment (or any appointments canceled without prior notification) your chart will be documented with a "no show" status and you will be charged a $25 fee. Please understand no insurance companies will cover this fee for you, regardless of your usual co-pay or deductible, therefore you will receive a bill for your missed appointments.

Please sign and date this to confirm you understand the above policies.

Thank you, NEW YORK HAND & PHYSICAL THERAPY

Patient Signature: _____ Date: _____

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Name: _____ Date: ___/___/___

Occupation: _____ Age: _____

Please describe the symptoms that brought you in today: _____

When/how did symptoms start? Date: ___/___/___ _____

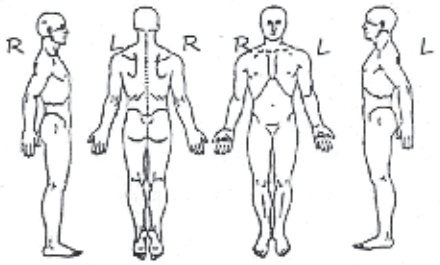
Did you have surgery for this condition? o Yes o No If yes, date: ___/___/___

Describe the nature of the pain: (check all that apply)

- o Sharp
- o Dull/achy
- o Throbbing
- o Tingling
- o Numbness
- o Shooting
- o Constant (76%-100%)
- o Frequent (51%-75%)
- o Occasional (26%-50%)
- o Intermittent (25% or less)
- o Increased in a.m.
- o Increased in p.m.

Other: _____

Mark an "x" over areas of your symptoms:



Please circle the intensity of your pain at **REST**:

0	1	2	3	4	5	6	7	8	9	10
No pain		Slight		Mild		Moderate		Severe		Worst possible

Please circle the intensity of your pain with **ACTIVITY**:

0	1	2	3	4	5	6	7	8	9	10
No pain		Slight		Mild		Moderate		Severe		Worst possible

What activities ***increase*** your symptoms? _____

What activities ***decrease*** your symptoms? _____

Have you had any imaging for this condition (X-rays/MRI/other)? _____

What was your level of activity/exercise prior to this condition? _____

Is there anything that you are unable to do in your daily life due to the current condition?

Please explain: _____

Have you experienced any of the following in the past 6 months? (check all that apply)

- o Unexplained weight loss/gain >10 lbs
- o Unexplained nausea & vomiting
- o Unexplained fatigue
- o Incontinence
- o Night sweats
- o Night pain
- o Fainting spells
- o Pain not relieved by change in position
- o Falls

Do you have any of the following current or previous medical conditions? (check all that apply)

- o High blood pressure
- o Diabetes
- o Heart, kidney, or thyroid conditions
- o Difficulty breathing
- o Asthma
- o Cancer
- o Osteoporosis/osteopenia
- o Osteoarthritis
- o Rheumatoid arthritis

Other: _____

Please list any medications you are taking: _____

Please specify previous surgeries/fractures/serious injuries, with approximate dates: _____

Please specify any allergies to latex, adhesives, or medications: _____

For women: Are you pregnant? o Yes o No If yes, how far along? _____

Patient's signature: _____