Hands On Physical Therapy
2710 Grand Avenue
Bellmore, NY 11710
Ph. 516-781-9555 / Fax. 516-442-1056
www.handsonptny.com

PATIENT INTAKE FORM

Please fill this form out completely. Thank You!

Patient Information

Name: _____ Employer: _____

Address: _____ Address: _____

City/State/Zip: _____ City/State/Zip: _____

Phone: _____ Phone: _____

Date of Birth: _____ Ht/Wt _____ M/F _____

Social Security: _____ Occupation: _____

Present Medical History/ Medication:

_____

Past Medical History:

_____

Chief Complaints:

_____

_____

Is this a car accident case? Yes or No
Is this a worker's compensation case? Yes or No
Surgery/Injury:_____Date of surgery or Injury: _____

Previous Therapy: _____

Primary Doctor: _____
Phone number: _____ Fax Number: _____

Referring Doctor: _____

Phone Number: _____ Fax Number: _____

Patient Signature: _____ Date: _____

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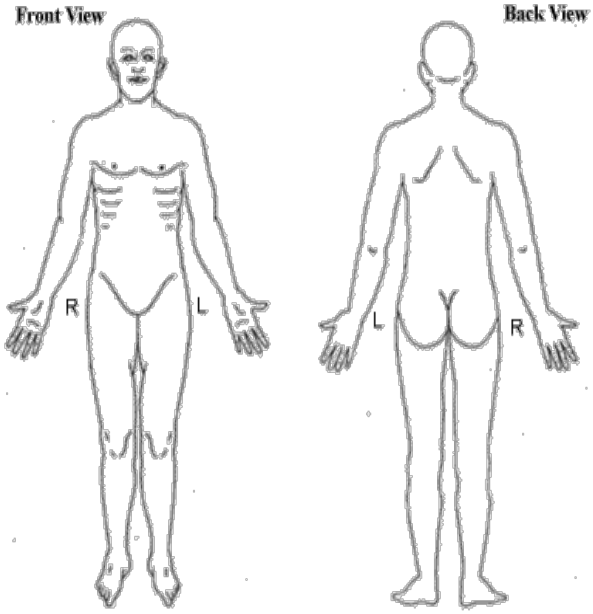

(X) Sharp
(+) Numb/Tingling
(#) Dull/Aching
(B) Burning

Pain Level: _____ (*From the scale 0-10)*

When did the pain started? _____

How did the pain start?

- **Suddenly**
- **Gradually**
- **Pulling**
- **Lifting**
- **Injured at work**
- **Bending**
- **No apparent reason**
- **Other**

What Activities make the pain worse?
(*Circle one)*

Exercise **Bending Forward**
Sitting **Banding Backwards**
Walking **Coughing**
Sneezing

What reduces the pain? *(Circle One)*

Lying down **Pain Pills**
Injection for pain **Muscle relaxants**
Standing **Walking**
Nothing **Other**

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PATIENT INTAKE FORM

Please fill this form out completely. Thank You!

ASSIGNMENT OF BENEFITS

Patient Name: _____
Social Security: _____

I Instruct and direct that _____insurance company to pay check made out and mail to the address given below:

HANDS ON PHYSICAL THERAPY
865 Merrick Road, Suite 201
Baldwin NY, 11510

Professional or Medical benefits allowable and otherwise payee to me under my current insurance policy as a payment towards the total charge for professional services rendered. This is a direct assignment of my rights and benefits under my policy

A photocopy of the assignment should be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, physician, or attorney involved in the case.

CONSENT OF TREATMENT:

I understand that I have been referred for rehabilitative treatment and care to Hands On Physical Therapy, P.C. A therapist representing Hands On Physical Therapy, P.C. will describe for me my individual treatment plan. I understand that I have the right to ask and have my questions answered prior to receiving treatment. By signing this agreement, I consent to have Hands On Physical Therapy, P.C. provide assessment, treatment and care as prepared by my physician and/or recommended by my therapist. I further authorize Hands On Physical Therapy, P.C. to release too appropriate from agencies, any information relating to all claims for benefits submitted on behalf of myself and/ or my dependents.

Patient Signature: _____ Date: _____

Witness (with relationship to patient): _____

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PATIENT INTAKE FORM **Please fill this form out completely. Thank You!**

Signature On File:

I request that payment of authorized benefits be made on my behalf to Hands on Physical Therapy and/ or its providers for services furnished to me. I authorize any holder of medical information regarding me to be released to Empire Medicare Services or any other Medical carrier, Workers Compensation, No Fault insurance carriers with any information needed to determine these benefits payable for related services. I understand that I am responsible for any amount not covered by my insurance. I permit a copy of this authorization to be used in place of the original.

I designate the following representative who the provider can communicate with on my behalf. I am aware that of I do not designate anyone, the doctor unable to speak to anyone in my family regarding my medical care and / or condition.

Print Name:

Last Name: _____ First Name _____

Relationship _____

Primary Phone: _____ Secondary: _____

Patient Signature: _____ Date: _____

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Privacy Practices

PLEASE **SIGN. Thank You!**

Notice of Privacy Practices

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical 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 personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operation.

- TREATMENT means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would be sending medical information to the referring physician.

- PAYMENT means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill and/or chart notes for your visit to your insurance company for payment.

- HEALTH CARE OPERATIONS include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be sending charts to the physical therapy network for quality assurance review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders, reschedule appointments, or provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to receive and accounting of disclosures of protected health information.

- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a copy of the revised Notice of Privacy Practices from this office

Patient Signature: _____ Date: _____

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No- Fault Intake Form

Date of Accident:_____ **Accident State:**_____

Patient Information

Last Name:_____ **First Name:**_____

Address:_____

City:_____ **State:**_____ **Zip code:**_____

Insurance Information

Insurance Name: _____

Claim Number:_____

Claim Adjuster:_____ **Phone Number:** _____

Description of Accident: _____

_____

_____

_____.

Attorney Information

Have you retained an attorney? Yes/No

Attorney's Name:_____ **Phone:**_____

Address:_____

City:_____ **State:**_____ **Zip code:**_____

Patient Signature:_____ **Date:**_____

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Workers Compensation Intake Form

Date of Injury:_____ **Injury State:**_____

Patient Information

Last Name:_____ **First Name:**_____

Address:_____

City:_____ **State:**_____ **Zip code:**_____

Insurance Information

Insurance Name: _____

WCB Case No:_____ **Carrier Case No:**_____

Claim Adjuster:_____ **Phone Number:** _____

Description of Accident: _____

_____

_____

_____.

Patient Signature:_____ **Date:**_____

KAIZEN CHIROPRACTIC, P.C.
2710 Grand Avenue
Bellmore, NY 11710
www.KaizenNY.com
Phone: 516.781.9555 Fax: 516.781.2871

Patient Care Text Messaging/Emailing Consent Form

DECLARATION

I consent to the practice contacting me by text message/email for the purposes of health promotion and for appointment reminders.

I acknowledge that appointment reminders by text/email are an additional service and that these may not take place on all occasions, and that the responsibility of attending appointments or cancelling them still rests with me. I can cancel the text message/email facility at any time.

Text messages are generated using a secure facility. I understand that they are transmitted over a public network onto a personal telephone and as such may not be secure. However, the practice will not transmit any information which would enable an individual patient to be identified.

I agree to advise the practice if my mobile number changes or if this is no longer in my possession.

Patient Name: _____
Please print

Signature: _____

Home telephone number: _____

Mobile telephone number: _____

Cell Carrier: _____

Email: _____

The practice does not share mobile phone/email contact details with any external organization.

☐ I DO NOT CONSENT TO THE PRACTICE CONTACTING ME BY TEXT MESSAGING

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.**

Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.