

**BODYFIT PHYSICAL THERAPY AND WELLNESS**

**NEW PATIENT REGISTRATION FORM**

**Patient Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M / F SS #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Email: \_\_\_\_\_

- Check here if you do not wish to receive email updates from info@bodyfitpt.com

Referring Physician: \_\_\_\_\_

Is the injury work or accident related? \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Employment Information**

Employer / Address: \_\_\_\_\_

Occupation: \_\_\_\_\_

**Insurance Information** (If you provide your insurance card, you may omit this section)

Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

SS # of Insured: \_\_\_\_\_ Birth Date of Insured: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer of Insured: \_\_\_\_\_

**Authorization to Release Information and Guarantee of Account**

I authorize BodyFit Physical Therapy and Wellness, PLLC to bill my insurance company directly, and I authorize payment of benefits directly to BodyFit Physical Therapy and Wellness, PLLC. I authorize BodyFit Physical Therapy and Wellness, PLLC to release medical or other information necessary to process this claim.

I understand that I am ultimately responsible for my physical therapy charges, and I agree to pay my deductible and co-payment/co-insurance. I understand that some insurance companies require pre-authorization for treatment or have reimbursement limits on physical therapy treatments. I understand that I am responsible for knowing and meeting the requirements of my insurance plan.

I will immediately notify BodyFit Physical Therapy and Wellness, PLLC of any changes in my personal information or in my insurance coverage.

Initial: \_\_\_\_\_

**Direct Access / Prescriptions**

New York State law allows patients to be seen *without* a prescription for the first 30 days or 10 visits (whichever comes first). Any visits beyond this time period will require a physical therapy prescription from a New York medical doctor (MD), osteopath (DO), podiatrist (DPM), dentist (DDS or DMD), nurse practitioner (NP), physician assistant (PA), or midwife (CNM). Please check with your insurance company for their specific policy, because some insurance companies still require prescriptions at all times for payment. It is your responsibility to keep track of your visits and to attain necessary prescriptions.

Initial: \_\_\_\_\_

**Cancellation Policy**

Once an appointment is made, please remember that this time has been reserved for you. Therefore, you will be charged \$75.00 for missed or cancelled appointments without at least 24 hours advance notification. This fee is not billable to any insurance company.

Initial: \_\_\_\_\_

I understand and agree to the above policies.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Assignment of Benefits** (For Oxford and Empire BCBS patients only)

As a courtesy to you, we will bill your insurance company directly and expect to receive payment from them. However, your insurance company has a policy of forwarding reimbursement to you, the patient, rather than to us.

We require that you forward these insurance payment checks endorsed to BodyFit Physical Therapy and Wellness, PLLC, as well as the attached Explanation of Benefits (EOBs) upon receipt. If we do not receive these insurance payment checks within two weeks after you receive them, we will bill you for the full balance of the visit.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Acknowledgement of Receipt of Notice of Privacy Practices (NOPP)**

I authorize BodyFit Physical Therapy and Wellness, PLLC to release medical information to my physician(s), insurance companies, and any others who are involved in my care. This information may include reports of diagnosis, treatment, prognosis, recommendations, benefits payable, as well as any other data pertinent to my treatment.

I acknowledge that I have received a copy of The Notice of Privacy Practices. I have read, understand, and agree to these guidelines.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**BODYFIT PHYSICAL THERAPY AND WELLNESS**

**PATIENT HISTORY**

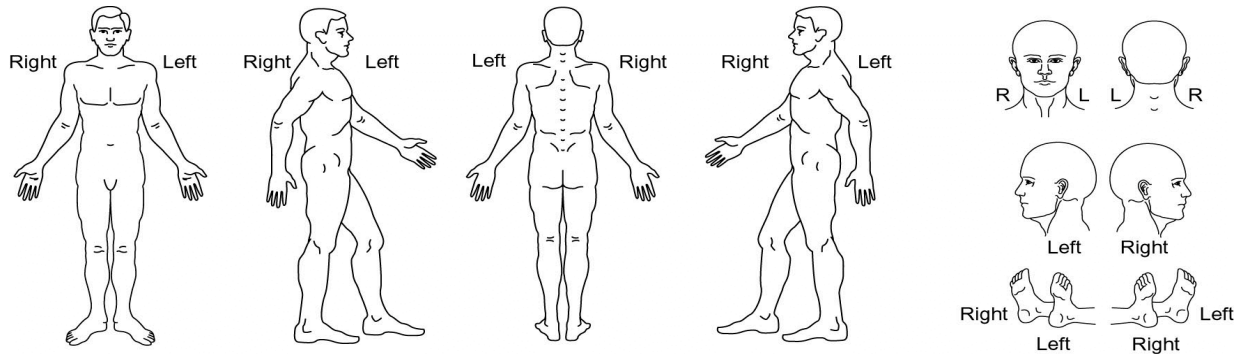
Last Name \_\_\_\_\_ First Name: \_\_\_\_\_ Date \_\_\_\_\_

What is your chief complaint? \_\_\_\_\_

Rate (circle) the intensity of your pain or chief complaint from 0 (none) to 10 (most severe):

0      1      2      3      4      5      6      7      8      9      10

Where is your problem? (Indicate on body chart below) O= Pain, X= Numbness/tingling



Indicate the nature of your symptoms (circle all that apply):

Sharp    Dull    Aching    Stiff    Shooting    Deep    Boring    Stabbing    Tingling    Numb  
Burning    Swollen    Constant    Intermittent

Onset of symptoms: \_\_\_\_\_ What happened? \_\_\_\_\_

What makes your symptoms worse? \_\_\_\_\_

What makes your symptoms better? \_\_\_\_\_

Are your symptoms:                      Improving?                      Staying the same?                      Worsening?

How have your symptoms affected your daily life/routine? \_\_\_\_\_

\_\_\_\_\_

What, if any, treatment have you received for this problem? \_\_\_\_\_

\_\_\_\_\_

Did this treatment help \_\_\_\_\_

General Medical History

Do the current symptoms interrupt your sleep?	Yes	No
Do your symptoms change with coughing or sneezing?	Yes	No
Have you had any recent changes in bowel or bladder function?	Yes	No
Do you experience any dizziness or vertigo?	Yes	No
Have you had any recent change in your weight or appetite?	Yes	No
Do you have any intolerance to hot or cold?	Yes	No
Do you have any bruising or bleeding disorders?	Yes	No
Have you had any skin changes such as rashes or discoloration?	Yes	No
Have you experienced any recent vision change (blurred, double vision)?	Yes	No
Have you had a recent episode of nausea or vomiting?	Yes	No
Are you pregnant?	Yes	No
Do you have osteoporosis?	Yes	No
What was the date of your last bone scan? _____		
Do you have any allergies or asthma?	Yes	No
If yes please specify: _____		
Do you have any cardiac problems?	Yes	No
Have you noticed any shortness of breath or decrease in exercise tolerance?	Yes	No
Do you have high blood pressure?	Yes	No
Do you have diabetes?	Yes	No
Do you have a history of cancer?	Yes	No
Do you have a history of neck or back problems?	Yes	No
Are there any other conditions or illnesses that we should be aware of?	Yes	No
If so, please specify: _____		
List any past surgeries that you have had: _____		
List any history of falls or traumas: _____		
List all medications that you are presently taking: _____		
_____		



## Notice of Privacy Policy

We have a legal responsibility to focus on the privacy and security of your Protected Healthcare Information (PHI). The federally mandated program, Health Insurance Portability & Accountability Act of 1996 (HIPAA), has set standards for the disclosure and protection of individually identifiable health information and any medical records related to those individuals. This Act gives you the right to understand and control how your health information is being disclosed. In compliance with HIPAA, we are notifying you of your responsibilities and how we are required to maintain privacy of your records.

We may disclose your PHI for the following purposes: treatment, payment and health care operations. We do not need further authorization if this disclosure is required by law, for public health purposes, to report abuse/neglect, is required by coroner or medical examiner, to prevent or lessen a serious or imminent threat to the health or safety of a person or the public, or is requested by military authorities if you are a member of the armed forces.

We may contact you by mail, phone, or email to remind you of appointments or to provide information about events at BodyFit Physical Therapy and Wellness. Unless you instruct us otherwise, we may leave a message for you on an answering device or with any person who answers the phone.

Other uses and disclosures will be made only with your written consent and authorization. Should you wish to revoke the authorization, you may do so in writing, and the sharing of your PHI will be stopped immediately.

You, the patient, may request in writing the following list of rights regarding your PHI:

- The right to request limits regarding the disclosure of your PHI (specifically related to the sharing with family members, close friends or any other person identified by you). We will carefully consider your request but are not legally required to agree to it. Restriction requests do not apply to the uses that we are legally required or allowed to make.
- The right to request how PHI is communicated to you by our practice.
- The right to request and copy your PHI. Request must be in writing, and we may charge a fee to cover the cost of copying and mailing.
- The right to request (in writing) a correction or otherwise update your PHI. We will consider the reason for an amendment but are not required to agree to a change.
- The right to request and receive a list of disclosures of any PHI made by our office.
- The right to request and receive a copy of this notice at any time.

Complaints: if at any time you feel your privacy rights have been violated you may file a written complaint to Attn: Privacy Officer, BodyFit Physical Therapy and Wellness, 147 W 24th Street, 7th Floor, New York, NY, 10011. Your complaint or concerns will not affect the quality of care provided to you by BodyFit Physical Therapy and Wellness.