Athalon Physical Therapy Registration Appt_____@_____

Name _____ DOB ____/____/_____

Phone # _____

Address _____ Apt# _____

City _____ State _____ Zip _____

What are you coming in for - Injury/Body part _____

Is this from a Car Accident/No Fault or Work Related? NF WC (circle one)

Are you using Insurance? Yes No

If your insurance plan requires a Referral, please have your Primary Care Doctor submit it to your insurance.

Primary Insurance _____ ID#_____

Name of Plan Subscriber _____DOB_____/_____/____ Relation_____

Insurance Company Phone # _____

Secondary Insurance _____ ID#_____

Name of Plan Subscriber _____DOB_____/_____/____ Relation_____

Referring Doctor_____

How did you hear about us _____Physician _____Direct Access _____

Please Complete

Home Phone #_____ Work # _____ Cell # _____

Gender M F Social Security # ____/____/____ email_____

Emergency Contact Name _____ Phone# _____

PRINT NAME: _____ SIGN x _____ DATE _____

CURRENT CONDITION/CHIEF COMPLAINT

1. Describe problem _____

_____

2. What activities is this problem interfering with? _____

_____

3. When did it begin? _____
4. What happened? _____
5. Are you seeing anyone else for the problem? _____

Have you received physical therapy this year? □ yes □ no If yes, for how long? _____

Have you had physical therapy for this condition? □ yes □ no If yes, for how long? _____

Are you: □ right handed? □ left handed?

MEDICAL/SURGICAL HISTORY - Please check if you have ever had:

□ Arthritis	□ Broken bones/fractures	□ Osteoporosis	□ Blood disorders
□ Multiple sclerosis	□ High blood pressure	□ Heart problems	□ Lung problems
□ Circulation/vascular problems	□ Diabetes/high blood sugar	□ Stroke	□ Seizures/epilepsy
□ Head injury	□ Muscular dystrophy	□ Parkinson's disease	□ Cancer
□ Low blood sugar/hypoglycemia	□ Allergies	□ Depression	□ Thyroid problems
□ Developmental/growth problems	□ Kidney problems	□ Repeated infections	□ Skin diseases
□ Ulcer/stomach problems	□Infectious disease (e.g. tuberculosis, hepatitis)		

□ Other: _____

Within the past year, have you had any of the following symptoms? (Check all that apply)

□ Chest pain	□ Heart palpitations	□ Cough	□ Hoarseness
□ Shortness of breath	□ Dizziness or blackouts	□ Coordination problems	□ Weakness in arms/legs
□ Loss of balance	□ Difficulty walking	□ Joint pain or swelling	□ Pain at night
□ Difficulty sleeping	□ Loss of appetite	□ Nausea/vomiting	□ Difficulty swallowing
□ Bowel problems	□ Weight loss/gain	□ Urinary problems	□ Fevers/chills/sweats
□ Headaches	□ Hearing problems	□ Vision problems	□ Other: _____

Have you ever had surgery? □ Yes □ No If yes, please describe and include dates: _____

MEDICATIONS: Please list any medications you take and for what reason: _____

_____

OTHER CLINICAL TESTS – Within the past year, have you had any of the following tests? (Check all that apply)

□ Angiogram	□ Arthroscopy	□ Biopsy	□ Blood tests
□ Bone scan	□ Bronchoscopy	□ CT Scan	□ Doppler ultrasound
□ Echocardiogram	□ EEG (electroencephalogram)	□ EKG (electrocardiogram)	□ EMG (electromyogram)
□ Mammogram	□ MRI	□ Myelogram	□ NCV (nerve condion velocity)
□ Pap smear	□ Pulmonary function test	□ Spinal tap	□ Stool tests
□ Stress test (e.g., treadmill, bicycle)		□ Urine tests	□ X-rays

SOCIAL/HEALTH HABITS

Do you smoke? □ Yes □ No If yes, how often? _____

Do you drink alcohol? □ Yes □ No If yes, how often? _____

Do you exercise? □ Yes □ No If yes, please describe the exercises _____

FAMILY HISTORY - Indicate what relative and age of onset, if known.

Heart disease: _____ Hypertension: _____

Stroke: _____ Diabetes: _____

Cancer: _____ Psychological: _____

Arthritis: _____ Osteoporosis: _____

Other: _____

For women only:

Do you have a history of/or currently have: Trouble with your period □Yes □No Complicated pregnancies? □Yes □ No

Are you pregnant, or think you might be pregnant? □Yes □No

Other gynecological or obstetrical difficulties? □Yes □No If yes, please describe: _____

Athalon Physical Therapy 115 East 57th Street, Suite 605, New York, NY 10022

PATIENT AGREEMENT

At Athalon Physical Therapy we are aware of how important your time is, so we make every effort to begin your appointment at its scheduled time. We are also sensitive to the fact that emergencies beyond your control do occur. However, cancellations, no shows and late arrivals hinder our ability to administer treatment to you, as well as decrease our ability to accommodate other patients. Therefore, we require the following patient agreement:

- To cancel an appointment, we require a notice of **one full business day** prior to the scheduled appointment; answering machine is on at all times. (e.g. Monday appointments require a notice on the Friday before.)
- Cancelled or missed appointments result in **a $75 charge**. This fee is not covered by insurance.
- An appointment without proper notification can be **rescheduled** to another day within the same week to **avoid the cancellation charge** as long as it does not interfere with previously scheduled appointments or cancelling an existing appointment.
- If you are running late, we request that you call us at **212-838-8023.** If you arrive more than 15 minutes late, we will do our best to accommodate you but cannot promise that we will be able to treat you.
- Please inform the front desk of all schedule changes.
- Please be advised that we submit to your insurance for reimbursement of our services. If there is an outstanding balance remaining, you may be responsible for that balance.

My signature confirms my agreement to the above conditions.

_____ _____

Patient Signature Date

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain an current copy of its *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Signature:_____ Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment form, but was unable to do so as documented below:

Date:	Initials:	Reason: