161 Atlantic Ave Brooklyn, NY 11201 Fax: (718) 852-5290 Phone: (718) 852-6030

REGISTRATION

PERSONAL INFORMATION

Name: ______________________ Date of Birth: ____________

Social Security Number ______________________ Gender M ☐ F ☐

Marital Status ☐Single ☐Married ☐Divorced ☐ Widowed

Employment Status: Employed ☐ Full-time ☐ Part-time ☐Unemployed

Student ☐Full-time ☐ Part-time

Address: ______________________ ____________ ______ ______

Address, Street, Apt # City State Zip

Home Phone ______________ Cell Phone ______________

Work Phone ______________ ext ____ Email ______________

Emergency Contact ______________ Relationship ________ Phone ________

Referring Doctor: ______________

INSURANCE INFORMATION

Primary Insurance

Insurance Company ______________

Insurance/Member ID ______________

Secondary Insurance

Insurance Company ______________

Insurance/Member ID ______________

POLICIES AND CONFIDENTIALITY

Cancellations:

Please give a minimum of 24 hours notice for cancellations and appointment changes. Continuous cancellations without prior notice will result in a $40 service fee.

Confidentiality:

This office adheres to all HIPAA regulations regarding the confidentiality of patient records. Employees have access only to patient information necessary to properly perform the function of their jobs. This office will communicate with all insurance companies and other health care practitioners by letter, phone or fax upon permission from the patient (see below).

Patient Consent:

1. I have read and understand the cancellation policy
2. I authorize the release of any medical information necessary to process all claims and I authorize any staff of Atlantic Physical Therapy to communicate with all necessary insurance companies, health care practitioners as necessary by letter, phone, or fax
3. If assignment is accepted, I authorize and request my insurance companies to pay directly to Neil Moskovitz or Atlantic Physical Therapy benefits otherwise payable to me. I understand that accepting assignment is a courtesy extended to me by this office and that I am financially responsible for any coinsurance, deductibles, and services that are not covered or deemed "not medically necessary" by my insurance companies. Further, I understand that if an insurance claim is not paid within 45 days, I am responsible for the full amount immediately.
4. If assignment is not accepted, I understand that I am financially responsible for all services and payment is due at each visit unless other arrangements have been made.
5. If Neil Moskovitz or Atlantic Physical Therapy is a participating provider with Medicare and/or any other insurance companies, I understand that I am subject to the term conditions of the aforementioned insurance policies.

Signature ______________________ Date ____________

Bridging the gap from pain to function

PATIENT MEDICAL HISTORY

Name ____________________ Age ________

Referring Physician ____________________ Height ________

Is an attorney involved with your case? ____________ Weight ________

Have you had surgery for this injury? ________ Type of Surgery ____________

What is your primary problem? ____________________

	YES	NO
Are you taking any prescriptions or non-prescription medication?	___	___
Have you seen any specialists for this injury?	___	___
Have you had any diagnostic testing for this injury?	___	___

Do you or have you ever had any of the following:

___Allergies
___Anemia
___Arthritis/Swollen Joints
___Asthma, Bronchitis, Emphysema
___Blood Clots
___Bowel or Bladder Problems
___Cancer/Chemotherapy/Radiation
___Coronary Heart Disease or Angina
___Diabetes
___Dizziness or Fainting
___Emotional/Psychological Illness
___Epilepsy/Seizures
___Gout
___Heart Attack or Surgery
___Hernia
___High Blood Pressure
___Infectious Diseases
___Joint Replacement
___Multiple Sclerosis
___Numbness or Tingling
___Osteoporosis
___Parkinson's Disease
___Pacemaker
___Severe Headaches
___Shortness of Breath
___Stroke/TIA
___Thyroid Dysfunction/Goiter
___Varicose Veins
___Weakness
___Weight Loss/Energy Loss
___Ankle Injury
___Elbow or Hand Injury
___Knee Injury
___Hip Injury
___Lower Back Injury
___Neck Injury
___Pins or Metal Implants
___Recent Pregnancy or C-Section
___Currently Pregnant
___Do you smoke

Other conditions not listed ____________________

Patient Signature ____________________ Date ____________

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Bridging the gap from pain to function

INDIVIDUAL CONSENT

CONSENT TO USE OR DISCLOSE YOUR HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

____

PATIENT NAME

In providing service to you, we create and store health information that identifies you. We understand that this information about you and your health is personal, and we are committed to protecting the privacy of this information. We must obtain your one time consent before we treat you, obtain payment for our services, and conduct health care operations of the practice. Please read carefully the information below before signing this form.

Notice of Privacy Practices: We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail and we encourage you to read it. We want you to know, however, that the Notice of Privacy Practices is subject to change. If it is changed, you may obtain a copy of the revised notice by calling our office at (718) 852-6030, or asking for a copy at your next visit.

Revoking Consent: You have the right to revoke this consent at any time, except to the extent that the center has already taken action based upon your consent. For example, if you revoke your consent after the office has provided you with treatment, the office will be permitted to use or disclose your protected health information to bill for treatment. To revoke this consent, please write to our office.

Scope of Consent: By signing this consent form, I hereby authorize Atlantic Physical Therapy and its providers to use and disclose my personal health information, as necessary, for the purposes of obtaining medical treatment, facilitating the payment for such treatment and for normal business operations.

Patient Signature ______________________________ Date ______________________________

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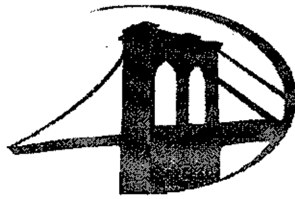

ATLANTIC PHYSICAL THERAPY

161 Atlantic Ave Brooklyn, NY 11201

Phone: (718) 852-6030 **Fax: (718) 852-5290**

Our office verifies insurance coverage before each evaluation, but please note it is the responsibility of the patient to understand his or her benefit plan. You should be sure to verify any out-of-pocket costs with your insurance company prior to your first appointment. Any co-pay, deductible or coinsurance cost is the responsibility of the patient. It is also important to inform our office of any changes to your insurance in order to avoid any unnecessary costs or lapses in coverage. As of your first visit, your insurance coverage is as follows:

Insurance ______________________________

Co-pay ______________

Deductible ______________

Deductible met so far ______________

Coinsurance ______________

Authorization required Yes No

Number of Visits Allowed Under Plan Terms __________

By signing below, you acknowledge that all costs associated with your treatment will be paid to Atlantic Physical Therapy.

______________________________ ______________

Signature of Patient Date