

Central Park Physical Therapy Registration

Today's Date:

Name:

Date of Birth:

Address:

City:

State:

Zip:

Email:

Phone:

Occupation

Referring MD:

Emergency Contact Name & Phone

How did you hear about Central Park Physical Therapy?

I am an Alumni. I have been to CPPT previously

Friend

Physician

Other

By signing **I authorize** Central Park Physical Therapy to keep my signature on file and to charge my credit card.

I assign benefits to the provider listed above. I understand that this form is valid for **one year** unless I cancel authorization through written notice to the healthcare provider.

Patient Name

Cardholder Name

Card Number

Exp. Date

CVC

Cardholders Signature

Medical History

Chief Complaint:

Date of Injury:

Current Symptoms (all that apply): Pain
AcuteNumbness
ChronicStiffness
Other

Weakness

Current medications:

Allergies:

History of surgeries:

Have you had Diagnostic or Rehabilitative Services for this injury?

MRI

X-rays

Results/other:

Do you have any of the following?

Asthma, Bronchitis or Emphysema

Shortness of Breath/Chest pain

Coronary Heart Disease

Pacemaker

High Blood Pressure

Heart Attack/Surgery

Stroke/TIA

Parkinson's

Blood Clot/Emboli

Epilepsy/Seizures

Thyroid Trouble/Goiter

Anemia

Headaches or Migraines

Diabetes

Cancer/Chemo/Radiation

Arthritis/Swollen Joints

Osteoporosis/Osteopenia

Varicose Veins

Gout

Sleeping Difficulties

Emotional/Psychological Problems

Prostate Disease

Bowel or Bladder Problems

Infectious Disease

Balance problems

History of falls

Vision/Hearing Difficulties

Dizziness or Faintness

Head Injury

Kidney Problems

Skin Disease

Ulcers, Colitis, Stomach Problems

Are you pregnant or trying?

HIV / AIDS

Other

Patient/Guardian Signature

Date:

Print Name:

Policies for Consent, Payment & Insurance Reimbursement

Central Park Physical Therapy is committed to providing you with the best possible service. In order to achieve this goal, please understand our policies.

We advise the scheduling of appointments at least one week in advance so that we may accommodate your needs. Payment for service is always due at the time services are rendered. We expect you to honor the appointments you schedule. You will be responsible for your session's payment if cancellations are not made 12 hours prior to the scheduled appointment.

A physician's prescription may be required for Physical Therapy services after one month of physical therapy treatments.

I hereby agree and give consent to treatment for my physical condition. I understand I will be responsible for payment for all services rendered in my home or the office. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs and all legal fees that are incurred.

OFFICE VISIT: CENTRAL PARK PHYSICAL THERAPY FEES (OUT OF POCKET)

- \$300.00 / 30 minute session
- \$600.00 / 60 minute session

HOME VISIT: CENTRAL PARK PHYSICAL THERAPY FEES (OUT OF POCKET)

- Above rates for treatment services plus \$300 travel charge for UES or midtown

Patient/Guardian Signature:

Date:

Print Name:

CENTRAL PARK PHYSICAL THERAPY

**30 East 60th Street, Suite 206
NEW YORK, NEW YORK 10022
212-765-4800**

HIPAA PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW PHYSICAL THERAPY INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) TO CARRY OUT TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS (TPO) AND FOR OTHER PURPOSES THAT ARE PERMITTED OR REQUIRED BY LAW. IT ALSO DESCRIBES YOUR RIGHTS TO ACCESS AND CONTROL YOUR PROTECTED HEALTH INFORMATION. "PROTECTED HEALTH INFORMATION" IS INFORMATION ABOUT YOU, INCLUDING DEMOGRAPHIC INFORMATION, WHICH MAY IDENTIFY YOU AND THAT RELATES TO YOUR PAST, PRESENT OR FUTURE PHYSICAL OR MENTAL HEALTH OR CONDITION AND RELATED HEALTH CARE SERVICES.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION: YOUR PROTECTED HEALTH INFORMATION MAY BE USED AND DISCLOSED BY YOUR THERAPIST, OUR OFFICE STAFF AND OTHERS OUTSIDE OF OUR OFFICE THAT ARE INVOLVED IN YOUR CARE AND TREATMENT FOR THE PURPOSE OF PROVIDING HEALTH CARE SERVICES TO YOU, TO PAY YOUR HEALTH CARE BILLS, TO SUPPORT THE OPERATION OF THE THERAPIST'S PRACTICE, AND ANY OTHER USE REQUIRED BY LAW.

TREATMENT: WE WILL USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION TO PROVIDE, COORDINATE, OR MANAGE YOUR HEALTH CARE AND ANY RELATED SERVICES. THIS INCLUDES THE COORDINATION OR MANAGEMENT OF YOUR HEALTH CARE WITH A THIRD PARTY. FOR EXAMPLE, WE WOULD DISCLOSE YOUR PROTECTED HEALTH INFORMATION, AS NECESSARY, TO A HOME HEALTH AGENCY THAT PROVIDES CARE TO YOU. FOR EXAMPLE, YOUR PROTECTED HEALTH INFORMATION MAY BE PROVIDED TO A CLINICIAN TO WHOM YOU HAVE BEEN REFERRED TO ENSURE THAT THE CLINICIAN HAS THE NECESSARY INFORMATION TO DIAGNOSE OR TREAT YOU.

HEALTH CARE OPERATIONS: WE MAY USE OR DISCLOSE, AS NEEDED, YOUR PROTECTED HEALTH INFORMATION IN ORDER TO SUPPORT THE BUSINESS ACTIVITIES OF YOUR THERAPIST'S PRACTICE. WE MAY CALL YOU BY NAME IN THE WAITING ROOM WHEN YOUR THERAPIST IS READY TO SEE YOU. WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION, AS NECESSARY, TO CONTACT YOU TO REMIND YOU OF YOUR APPOINTMENT. WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION IN THE FOLLOWING SITUATIONS WITHOUT YOUR AUTHORIZATION. THESE SITUATIONS INCLUDE: AS REQUIRED BY LAW, PUBLIC HEALTH ISSUES AS REQUIRED BY LAW, COMMUNICABLE DISEASES, HEALTH OVERSIGHT, ABUSE OR NEGLECT, FOOD AND DRUG ADMINISTRATION REQUIREMENTS, LEGAL PROCEEDINGS, LAW ENFORCEMENT, CORONERS, FUNERAL DIRECTORS, ORGAN DONATION RESEARCH, CRIMINAL ACTIVITY, MILITARY ACTIVITY AND NATIONAL SECURITY.

YOU MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING EXCEPT TO THE EXTENT THAT YOUR THERAPIST OR THE THERAPIST'S PRACTICE HAS TAKEN AN ACTION IN RELIANCE ON THE USE OR DISCLOSURE INDICATED IN THE AUTHORIZATION. YOUR RIGHTS FOLLOWING IS A STATEMENT OF YOUR RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION. YOU HAVE THE RIGHT TO INSPECT AND COPY YOUR PROTECTED HEALTH INFORMATION, UNDER FEDERAL LAW, HOWEVER, YOU MAY NOT INSPECT OR COPY THE FOLLOWING RECORDS, PSYCHOTHERAPY NOTES, INFORMATION COMPILED IN REASONABLE ANTICIPATION OF, OR USE IN, A CIVIL, CRIMINAL OR ADMINISTRATIVE ACTION OR PROCEEDING AND PROTECTED HEALTH INFORMATION THAT IS SUBJECT TO LAW THAT PROHIBITS ACCESS TO PROTECTED HEALTH INFORMATION.

YOU HAVE THE RIGHT TO REQUEST A RESTRICTION OF YOUR PROTECTED HEALTH INFORMATION. THIS MEANS YOU MAY ASK US NOT TO USE OR DISCLOSE ANY PART OF YOUR PROTECTED HEALTH INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS. YOU MAY ALSO REQUEST THAT ANY PART OF YOUR PROTECTED HEALTH INFORMATION NOT BE DISCLOSED TO FAMILY MEMBERS OR FRIENDS WHO MAY BE INVOLVED IN YOUR CARE OR FOR NOTIFICATION PURPOSES AS DESCRIBED IN THIS NOTICE OF PRIVACY PRACTICES. YOUR REQUEST MUST STATE THE SPECIFIC RESTRICTION REQUESTED AND TO WHOM YOU WANT THE RESTRICTION TO APPLY. YOUR THERAPIST IS NOT REQUIRED TO AGREE TO A RESTRICTION THAT YOU MAY REQUEST

SIGNATURE BELOW IS ONLY ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THIS NOTICE OF OUR PRIVACY PRACTICES:

Signature

Print Name

Date