REGISTRATION

Today's Date: ____/____/_____

Name: _____Date of Birth: ____/____/____

Address: _____

City_____ State _____ Zip_____

Email:_____

Phone: (C) _____

Referring MD: _____Occupation: _____

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 _____

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 though 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 Numbness Stiffness Weakness Acute Chronic Other_____

Current medications: _____

Allergies: _____

History of any surgeries: _____

Have you had Diagnostic or Rehabilitative Services for this injury? MRI X rays 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 ___
Infectious Disease/Tuberculosis/Hepatitis ___
Diabetes ___
Cancer/Chemo/Radiation ___
Arthritis/Swollen Joints ___
Osteoporosis ___
Varicose Veins ___
Gout ___
Sleeping Difficulties ___
Emotional/Psychological Problems ___
Prostate Disease ___
Bowel or Bladder Problems ___
Headaches ___
Vision/Hearing Difficulties ___
Dizziness or Faintness ___
Head Injury ___
Kidney Problems ___
Skin Disease ___
Ulcers, Colitis, Stomach Problems ___
Are you pregnant? ___
HIV / AIDS ___
Balance problems ___
Other _____

Patient/Parent/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 PHYSCAL THERAPY FEES (OUT OF POCKET)

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

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

- Above rates for treatment services plus $300 travel charge

Patient's Signature/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