Name: _____ Date_____

Please Circle all that apply:

Irregular heartbeat/AFib

Angina

Pacemaker

Heart attack

Heart valve problem

Bleeding disorder

High Blood pressure

Kidney disorder/disease

OTHER: _____

Rheumatoid Arthritis

High cholesterol

Asthma

Emphysema

Chronic bronchitis

Thyroid (over/under active)

Neurological conditions

Cancer(s)

Smoker/Past smoker/vaper

Osteoporosis

Osteopenia

Blood clots

Headaches

Migraine

Seizures/Epilepsy

Mental health conditions

Anxiety, Depression

Fibromyalgia

Do you have diabetes? Yes/no Do you take insulin? Yes/no Blood sugar level average: _____.

Do you have any gastrointestinal issues: please list them: _____
_____.

Have you ever had surgery? (even as a child) : please list them: _____
_____
_____.

Family history: Does any of your immediate family (mother/father/siblings) have any cardiac/cancer history, if so please state: _____.

Have you had any falls in the last 2 years? Yes/no. If yes, how many? _____.

MEDICATIONS: _____
_____

Allergies: _____.

Is there a chance you are pregnant? YES/NO If you are/plan or become aware that you are, please inform your Physical therapist immediately.

Patient signature _____ Date_____.

PT/Office signature_____Date_____.

Performance Rehabilitation Registration Form

First Name _____ M.I. ____ Last Name _____

Address _____ Apt _____

City _____ State _____ Zip _____

Phone#: (Home) _____ (Cell) _____

Email: _____ Date of Birth _____ Age _____

Gender: _____ Pronoun: _____

Appointment Reminder (Please Circle): CALL EMAIL TEXT

In case of an emergency:

Name _____ Phone _____ Relationship to Patient _____

Physician Information

Referring Doctor's Name _____Phone _____

Primary Care Physician _____ Phone _____

Work's Comp/No Fault Info

Is injury due to: ☐ Auto Accident ☐ Work Accident ☐ Other _____Date of Injury _____ Date of Surgery_____

If Work or Auto Accident Did You File a Claim with Employer or Auto Insurance? Yes/No

How did you hear about us?

☐Been here before ☐ Doctor ☐Insurance Book ☐ Internet ☐ Friend/Relative: Name_____

Other_____

Patient Acknowledgement of Receipt of HIPAA Notice

I acknowledge that I have received or have been offered a copy of Performance Rehabilitation PT OT PLLC's Notice of Privacy Practices, effective April 14, 2003. I acknowledge my right and have been offered the option to request to receive communications of my personal health information by alternative means or at alternative locations. I understand that Performance Rehabilitation PT OT PLLC may refuse to accommodate my request if it is not reasonable.

***A current Notice of Privacy Practices for Performance Rehabilitation PT OT PLLC is also available at the check-in counter.**

_____ _____

Signature of Patient or Representative Date

For Staff Only: If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain their acknowledgment and the reason you could not obtain it:

_____.

PID#: _____ Date of Registration: _____ FOA: _____ OON Form Given to Patient _____

AUTH: _____ BOA: _____ Post Eval Newsletter: _____

Name: _____ Date_____

Treatment & Cancellation Policy

Your doctor has prescribed Physical Therapy for you. Just as a certified pharmacist dispenses a drug therapy, physical therapy must be dispensed by a licensed physical therapist (PT). In addition, for the full effect of your therapy to be realized, your treatment plan must be adhered to fully.

Physical therapy aims to restore the normal mechanics and function of your injured body part. This restoration is accomplished by using a variety of treatments, and thus requires consistent attendance 2-3 times per week. While we realize that cancellations do and must occasionally occur, we respectfully request that you give us 24 hours' notice prior to any cancellation. ***If you are having scheduling problems or any other problem with your treatment, please let us know immediately so that we may find the best possible solution regarding your situation.***

We feel that repeat cancellations lead to a poor recovery. In addition, it is not fair to us or to other patients who might have wanted to attend during your scheduled time. Patients who ***fail to show up for scheduled appointments two times without calling to indicate an interest in maintaining their treatment program may be discharged from therapy in addition to being assessed late cancellation / no-show fees.*** If you cancel ***more than twice in a two to three-week period, we may discharge you from your therapy.*** This might require you to get a new prescription from your doctor and a new authorization from your insurance carrier.

CONSENT FOR TREATMENT:

The undersigned hereby authorizes Performance Rehabilitation PT OT PLLC to provide professional services to me/my child/my legal ward. I understand as a patient, I am under the care and control of my physician(s) and that Performance Rehabilitation PT OT PLLC is not liable for any act or omission when providing treatment in accordance with my physician's instructions. I acknowledge that no guarantee or assurance has been, nor can be made by Performance Rehabilitation PT OT PLLC as to the result of the prescribed treatment.

There is a $25.00 No-Show/Cancellation Fee.

All appointments must be canceled the day prior to your appointment.
(or by the end of the business day on Friday for a Monday appointment),
to avoid charges for a no-show or late cancellation.
After hour messages regarding cancellations may be left at (914) 776-7310.
Insurance will not cover charges for no-show/late-cancellation fees.

We realize that you have a choice of where to go for therapy, and we are happy you chose us. We will be committed to you and to the treatment of your injury. No show appointments will result in removal of future appointments unless we receive confirmation from you by the end of business that day that you want to continue your treatment.

Please sign below indicating you understand our policy: Your therapist's signature indicating this has been discussed with you.

Patient signature _____ Date_____.

PT/Office signature_____Date_____.

Performance Rehabilitation's Payment Policy and Healthcare Operations

RELEASE OF INFORMATION:

The undersigned hereby authorizes this medical office to disclose all or any part of the patient's medical record or other medical information to any person or corporation which is or may be liable for all or part of this medical office's charges or having the responsibility for reviewing such charges, including but not limited to this medical office or medical service organizations, health maintenance organizations, insurance companies, workers compensation claims, welfare funds, or peer review organizations. The undersigned agrees to the copying of all medical record(s) which is/are to be sent to a receiving facility in the event that the undersigned must be transferred to another provider/facility. The undersigned acknowledges and consents that medical records, test results and reports, and billing information may be sent electronically or via facsimile to another medical facility or physician office involved in the care of the patient or responsible for any part of the patient's charges.

REQUEST/ PAYMENT, ASSIGNMENT OF BENEFITS,& RELEASE OF INFORMATION FOR MEDICARE/MEDICAID PATIENTS:

The undersigned requests payment of authorized Medicare benefits, if any, for any services furnished to the patient by Performance Rehabilitation PT OT PLLC, and hereby assigns such benefits otherwise payable directly to the patient, to Performance Rehabilitation PT OT PLLC, or the therapist(s) furnishing such services. The undersigned authorizes Performance Rehabilitation PT OT PLLC or such therapist to submit a claim for such services to Medicare. The undersigned authorizes any holder of medical or other information about the patient to release to Medicare, or its agent, claims processor, or utilization reviewers, any information needed to determine these benefits or benefits for related services.

ASSIGNMENT OF INDIVIDUAL BENEFITS:

In the event the undersigned is entitled to medical benefits of any type whatsoever arising out of any policy of insurance insuring patient or any other party liable to patient, the undersigned authorizes Performance Rehabilitation PT OT PLLC or therapist(s) to submit a claim for such services, and benefits are hereby assigned to this medical office for application on the patient's bill. It is agreed that Performance Rehabilitation PT OT PLLC may receive any such payment and such payment shall discharge the paying insurance company of any and all obligations under the policy to the extent of such payment. The undersigned and/or patient are responsible for charges not covered by the insurance. The undersigned certifies that the patient information given by or on behalf of the patient in applying for payment from all third party payers is correct.

FINANCIAL AGREEMENT:

The undersigned understands and agrees that the patient and guarantor are financially responsible to Performance Rehabilitation PT OT PLLC for charges for medically necessary services or services requested by or on behalf of the patient if such services are not covered by the patient's insurance plan or Medicare. The undersigned certifies that he/she has read the foregoing and is the patient or guarantor of this bill, or is duly authorized as the patient's general agent to execute the above and accept its terms. The undersigned acknowledges that insurance information

1. **Co-payments and deductibles.** **All co-payments and deductibles must be paid at the time of service.** This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. Final determination of your co-insurance amount is addressed when the claim is paid. Based on current information:
2. **Non-covered services.** Please be aware that some items or services may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. If this is to occur, you will be fully apprised of these services prior to receiving them so you can determine if you want to receive that service.
3. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
4. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
5. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
6. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. **Please be aware that should your account be referred to a collection agency, the percentage charged by the collection agency to our practice will be added to the total amount of your bill.**

PLEASE BE AWARE THAT WE RESERVE THE RIGHT TO DENY TREATMENT
IF YOUR FINANCIAL RESPONISBLILTY IS NOT COLLECTED THE DAY OF YOUR APPOINTMENT

Co-Payment responsibility due each visit: _____ **Cash Rate: First Visit _____**
Co-Insurance responsibility due each visit: _____ **Visits Following Evaluation_____**
Deductible:_____

Signature of patient or responsible party_____Date_____