New Patient Registration & Personal Information

Last Name/First Name: _____

Address: _____ Apt.: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____Work: _____ Cell: _____

E-mail: _____ Referring Physician: _____

Social Security: _____ Marital Status: _____ Married _____ Single

Sex: ____ Male ____ Female Date of Birth: _____ Referred By: _____

In case of emergency contact: _____ Phone#: _____

Insurance Information:

Name of Insured: _____ Policy#: _____

Insurance Carrier: _____ Phone# _____

Relationship to Insured: _____ Self _____ Spouse _____ Child/Financial Dependent Date-of-birth:__/___/___

Responsible Party (If different from above):_____ Phone: _____

Employment Information:

Employer: _____

Address: _____

Electropads

All patients **will be charged a one-time fee of $20** for their own set of electropads. These pads are adhesive to your skin and used as part of ultrasound/E-stim therapy. Please ask therapist or front desk if you have any questions about the use of electropads.

I hereby assign all rights, privileges and remedies to payment for health care services to Gary P. Guerriero, P.T.P.C. I also authorize Gary P. Guerriero, P.T.P.C., having treated me, to release to government agencies, insurance carriers and all others who are financially liable for my care, all information needed to substantiate payments for care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment. I have read and understand the privacy practices of the office.

Patient Signature: _____ Date: _____

PATIENT AGREEMENT

Thank you for choosing Gary P. Guerriero, P.T.P.C. at the U.S. Athletic Training Center for your therapy needs. We look forward to working with you to meet your therapy goals. We ask that you **read** and sign this agreement. The following information lays out our billing, payment, scheduling and cancellation procedures. If you have any questions please ask for clarification.

- All patients attending physical therapy **must have a valid written prescription by a medical doctor, osteopath or podiatrist**. Insurance companies may not honor claims that are not accompanied by this prescription. Prescriptions will need to be updated throughout treatment.
- As a courtesy we will assist the patient in submitting claims to their primary insurance carrier. **We do not forward claims to secondary insurance carriers**. Occasionally insurance carriers request additional information in order to process claims which may require the patient's assistance.
- Patients must notify the billing department immediately of any changes to insurance coverage or demographic information. Failure to do so may result in the patient being responsible for the full amount of services rendered.
- **Patients are responsible for any co-payment, deductible, co-insurance or any non-covered items by their insurance company. Payment is expected at the time services are rendered or by credit card on file**.
- Patients are responsible for scheduling and confirming appointments with the front desk. Any changes in scheduling should be handled with the front desk and **NOT** the therapist. Due to high volume of patients, we recommend scheduling all visits at least two weeks in advance to reserve the desired times with a given therapist. Appointments are available: Monday through Friday 6:00am – 6:40pm, Saturday 10:00am – 1:20pm.
- **Scheduled appointments must be cancelled at least 24 hours in advance to avoid a cancellation fee of $100. Similarly, a $100 fee will be assessed if a patient does not show up for a scheduled appointment**. The fee is not waived for business or travel and is not billable to any insurance carrier. Patients are advised to obtain printouts of their schedule from the front desk to avoid any errors.

I have read, understand and agree to all the above terms.

X_____

Patient/Guarantor Signature Date

Credit Card Agreement

(OPTIONAL)

To keep your account up-to-date we recommend leaving a credit card on file to handle any of the healthcare costs accrued during your course of treatment. We will bill your credit card after services are rendered for any services, co-payments, deductibles or co-insurance for which you are responsible within the billing period. We will then send you a copy of the bill and a receipt of each transaction for your records.

NAME (PLEASE PRINT)

TYPE: ☐ VISA ☐ MC ☐ AMEX ☐ DISC ☐ DINERS CLUB

CARD # EXP DATE CCID

[ ] Billing Information If Different Than Patient Information:

Name On Card: _____

Street Address: _____ Zip: _____

Late Cancel and No Show fees: *There is a $100 fee for canceling or missing an appointment. We will initially send you a statement for these fees. If we have not heard from you to dispute the charge by the next billing cycle, it will be processed to your credit card.*

I hereby authorize Gary P. Guerriero, P.T.P.C. to charge the credit card listed above for any and all fees for which I am responsible. These fees include co-payments, deductibles, co-insurance, equipment, non-covered items and undisputed Late Cancel/No Show charges.

CARDHOLDER SIGNATURE DATE

DATE

PERSONAL HEALTH/INJURY HISTORY

Please complete form for each new diagnosis

Reason For Todays Visit: _____

HISTORY OF INJURY:

Where is the pain? _____

How long has it hurt? _____

PREVIOUS PHYSICAL THERAPY

FOR WHAT? _____

_____

FOR HOW LONG? _____

_____

MEDICAL HISTORY

SURGERY? _____

_____

ANY RELEVANT MEDICAL CONDITIONS? _____

_____

MEDICATIONS – CURRENT ☐ None (Please list all dosage)

_____

_____

_____

Social History

Are You Obligated to Participate In Athletic Activity as Part of Your Job	☐ No ☐ Yes
Regular Exercise:	☐ No ☐ Yes
Sleep Hours/night	☐1-4 ☐ 4-7 ☐ 8-10 ☐ 10+
How Many Hours Do You Spend In a Desk Chair	☐1-4 ☐ 4-7 ☐ 8-10 ☐ 10+
Tobacco Use:	☐ No ☐ Yes
Drug Use	☐ No ☐ Yes
Alcohol Use	☐ No ☐ Yes
How Many Drinks Per Weeks	☐ 1-5 ☐5-10 ☐ 10-20 ☐ 20

Do You Have Any Problems Related To the Following? Please explain any Yes answers in the space provided.

Metal Implants

Is there Metal Anywhere in Your Body? □ No □Yes_____

Where exactly is this metal? _____

How long has it been there? _____

Pregnancy

Are you pregnant? □ No □ Yes_____

Could you be pregnant? □ No □ Yes _____

If Yes What Trimester? □ 1st □ 2nd □ 3rd

Headaches

Do You Get Frequent Headaches? □ No □Yes_____

Are you getting headaches due to your pain? □ No □Yes_____

How long have you been getting headaches?_____

Is it disrupting day-to-day activity? □ No □Yes_____

Seizures

Have you ever had a seizure? □ No □Yes_____

Are you currently undergoing care for seizures?□ No □Yes_____

When was your last seizure?_____

Unclassified Pain

Do You have unclassified Pain? □ No □Yes

If Yes where is it? _____

How long has it been there?_____

Muscular/Neuro Muscular

Have you been diagnosed with a muscular disease? □ No □Yes

If Yes which one? _____

When was your diagnosis made?_____

Depression/Anxiety

Do you feel depressed? □ No □Yes_____
Do you feel anxious? □ No □Yes_____
Do you frequently cry? □ No □Yes_____
Do you take your pain out on other people? □ No

Arthritis

Arthritis Diagnosis Ever? □ No □ Yes_____
Present Arthritis Treatment? □ No □ Yes _____

Heart

Do You Have Heart disease? □ No □ Yes_____
Do You Have a Pacemaker? □ No □ Yes
Have You Ever Had a Heart Attack? □ No □ Yes_____

Cancer

Cancer Diagnosis Ever? □ No □ Yes_____
Present Cancer Treatment? □ No □ Yes _____

Diabetes

Diabetes Diagnosis Ever? □ No □ Yes_____
Present Diabetes Treatment? □ No □ Yes _____

Dizziness

Do You Get Dizzy? □ No □ Yes_____
Do You Fall? □ No □ Yes
If you fall when was the last time you fell? _____

Hypertension

Hypertension Diagnosis Ever? □ No □ Yes_____
Present Hypertension Treatment? □ No □ Yes _____

Nervous System

Have you been diagnosed with a nervous system disease? □ No □Yes
If Yes which one? _____
When was your diagnosis made?_____

HIV

Have you ever been diagnosed with HIV? □ No □ Yes_____

Undergoing current HIV treatment? □ No □ Yes _____

What Year was this diagnosis made? _____

Skin Rash

Frequent Skin Rashes? □ No □ Yes_____

Present Skin Rash Treatment? □ No □ Yes _____

Is the Skin Rash Diagnosed? □ No □ Yes_____

Activity Limitations

I cannot sit or stand for a prolonged period	□ False	□True_____
I cannot walk long distances	□ False	□True_____
I cannot ascend or descend stairs	□ False	□True_____
I have trouble sleeping	□ False	□True_____
I cannot commute	□ False	□True_____
I cannot participate in athletic activity	□ False	□True_____
This injury has impacted me emotionally	□ False	□True_____
I cannot engage in overhead activity	□ False	□True_____
I am frustrated	□ False	□True_____
I cannot get in or out of the bathtub	□ False	□True_____
I have difficulty participating socially	□ False	□True_____
I cannot engage in movies or concerts	□ False	□True_____
I cannot drive a car	□ False	□True_____
I cannot blow dry my hair	□ False	□True_____
I have difficulty concentrating	□ False	□True_____
I cannot engage in personal care	□ False	□True_____
I cannot open a tight jar	□ False	□True_____
I cannot turn a key	□ False	□True_____
I cannot push a heavy door	□ False	□True_____
I cannot place an object on a high shelf	□ False	□True_____
I cannot make a bed	□ False	□True_____
I cannot change an overhead light bulb	□ False	□True_____
I cannot prepare my own meals	□ False	□True_____
I cannot perform light activities in the home	□ False	□True_____
I cannot engage with my child	□ False	□True_____

Notice of Privacy Practices

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

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer or other entity responsible for payment. For example, your health plan may request and receive information on dates of service, the services provided and the medical condition being treated.

Health Care Operations. Your health information may be used as necessary to support the day-to-day activities and management of the U.S. Athletic Training Center/Gary P. Guerriero, P.T.P.C. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality as statistic **not** by name.

Law Enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations and to comply with government mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as requirement by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of that authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Individual Rights

You have certain rights under the federal privacy standards. These include

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

U.S. Athletic Center/Gary P. Guerriero, P.T.P.C. Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.
We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and/or states laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the U.S. Athletic Training Center/Gary P. Guerriero P.T.P.C. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Management

U.S. Athletic Training Center/Gary P. Guerriero, P.T.P.C.
515 Madison Avenue, 3rd Floor

New York, New York 10022

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.
You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you can contact for further information concerning our privacy practices is:
Matthew Guskin
U.S. Athletic Training Center/Gary P. Guerriero, P.T.P.C.
515 Madison Avenue, 3rd Floor
New York, New York 10022
212-355-8440

Effective Date

This notice is effective on or after July 10, 2008.

Acknowledgement of Receipt of Notice of Privacy Practices
U.S. Athletic Training Center/Gary P. Guerriero, P.T.P.C. reserves the right to modify the privacy practices outlined in the notice.

I have read a copy of the Notice of Privacy Practices for U.S. Athletic Training Center/Gary P. Guerriero, P.T.P.C.

Name of Patient (Print or Type)

Signature of Patient Date

Signature of Patient Representative Date
(required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient

U.S.A.T.C Mobile Device Policy:

In order to provide optimal service, our office is implementing a no cellular device policy while receiving therapy. Mobile devices may be used when receiving ice and electrical stimulation, but may not be used when performing exercises or using equipment. This is in order to ensure the safety of our patients, as distractions can lead to misuse of equipment, falls, and poor form with exercises, increasing risk of injury. Also, as a courtesy for our other patients and patrons of the gym, please restrict your cellular phone conversations to the waiting area in the front or in the hallway. These will not be permitted in patient care areas, including while on the game ready and electrical stimulation systems. This is also to adhere to our privacy policies, as patient information may be exchanged and overheard during a phone conversation. Your privacy is important to us, and we would like you to rehabilitate from your injury as quickly as possible, these measures will improve your therapy experience and increase the speed of recovery. As always, photos are not permitted in any part of U.S.A.T.C. due to privacy laws.

We thank you for your cooperation,

The team at U.S.A.T.C.

Signature denotes you have acknowledged that you will adhere to the policy as explained above; absolving U.S.A.T.C/Gary Guerriero of responsibility should any injuries occur due to mobile electronic device usage while in therapy.

Signature:_____Date:_____