PATIENT REGISTRATION FORM

Name: ______________________________ Date: ____________
Address______________________________ Apt#_____ Date of Birth__________
City________________________ State_____ Zip Code________________
Sex: M F HOME# (___) ______________ Spouse Name________________
Marital Status: [S] [M] [D] [W] [Sep.] Social Security#________________
Employer____________________ Address________________________
Work# (___) ____________________ Occupation____________________

Whom can we contact in case of emergency?
Name____________________ Relationship____________________
Phone# (___) ____________________Address________________________
Referring Physician________________ Phone (___) ________________

Insurance Name: ____
Name of Insured ________________Relationship to insured________________
(Employer of insured)________________**SS#**__________ **Date of Birth**________

E-Mail Address: ____

Have you had any accident(s) prior to coming to our office for physical therapy?
Car accident_____ Work related accident____ describe other ________________________

Date of Accident: __________ Place of accident________________________
Was the case filed? Yes____ No___
Name of Attorney: ______________ Phone# (_____) ________________________

AUTHORIZATION TO RELEASE INFORMATION
ASSIGNMENT OF BENEFITS*AGREEMENT/CONTRACT

I hereby authorize Oshman & Barteck P.T to release to the insurance company(s) and or attorney named above any information acquired in the course of my examination or treatment (if patient is a minor, parent or guardian sign).

I hereby agree to full responsibilities for all expenses by or on account of the patient and hereby assign to Oshman & Barteck P.T any and all insurance and settlement benefits due me to the full extent of my financial obligation to said clinic.

Patients Signature: ______________________________ **Date:** ______________

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PATIENT REGISTRATION FORM

Oshman & Barteck P.T is committed to providing you with the best possible service. If you have insurance, we will help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance in understanding our policies.
Payments/co payments for services are due at the time services are rendered: unless payment arrangement has been negotiated with your insurance company. In the event that a check you write is returned to us you will be charged $25. We will be happy to help you process your insurance claim form for your reimbursement.
You should be knowledgeable of your health insurance benefits. Do not assume that we know what benefits your benefits are. Your insurance contract is between you and your insurance company. We are not a part of your contract. In some instances, our insurance specialist can help you determine your maximum allows benefits.

A fee of $25 will be charged for a no show appointment and cancellation not made 12 hours prior to the scheduled appointment. Insurance companies do not pay for no shows "visits". We expect you to honor the appointment you schedule. In the event you do not attend two scheduled appointments, you will be considered for discharge from our service.
We advise the scheduling for appointment at least one week in advance so that we may accommodate your needs. We also advise if possible, to schedule your appointments with the same therapist for the length of your treatment. Scheduling with the same therapist is not necessary, but may provide efficient continuity of care.

MEDICAL CONDITIONS

Please list any Medical Conditions:____________________

____

____

____

Please list any Allergies or Adverse Reactions:____________________

____

____

____

Please list Medications Currently Taken:____________________

____

____

____

Other Medical Information You Wish Us To Know:____________________

____

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____

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Patient's Signature: ____________________ Date____________________

Parent or guardian signature (if minor/student):____________________Date______

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OSHMAN & BARTECK PT NOTICE OF PATIENT INFORMATION PRACTICES

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

Oshman & Barteck PT's LEGAL DUTY

Oshman & Barteck PT is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Oshman & Barteck PT uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, **Oshman & Barteck PT** may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you. **Oshman & Barteck PT** may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by the law. In any other situation, **Oshman & Barteck PT's** policy is to obtain your written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time. Access to medical records is by authorized personnel only. Records will be in appropriate secure storage. Electronic records access is by authorized personnel only. All records are located and stored in such a way as to prevent any unauthorized access

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at anytime. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other that treatment, payment or other related administrative purposes. You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically ordered by you, when required by law or in emergency circumstances. **Oshman & Barteck PT's** will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that **Oshman & Barteck PT** may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclose my personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information Oshman & **Barteck PT's** health information practices or if you have a complaint, please contact Steven Barteck, Oshman & Barteck PT 124 West 79th St 1B New York NY
Telephone 212-874-2221 Fax 212-874-1940

PATIENT INFORMATION CONSENT FORM

I have fully read and understand **Oshman & Barteck PT's** Notice of Information practices. I understand that **Oshman & Barteck PT** may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that **Oshman & Barteck PT** will consider requests for restriction on a case by case basis, but does not have to agree to request for restrictions.

I hereby consent to the use and disclosure of my personal health information for the purposes as noted in **Oshman & Barteck PT's** Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at anytime.

____ Date______________________

Patient Name

____ Date______________________

Signature

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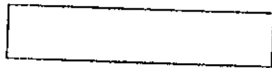
Patient Health Questionnaire - PHQ

Form PHQ-202



rev 7/18/05

Patient Name ______________________ **Date** ______________

1. Describe your symptoms ______________________

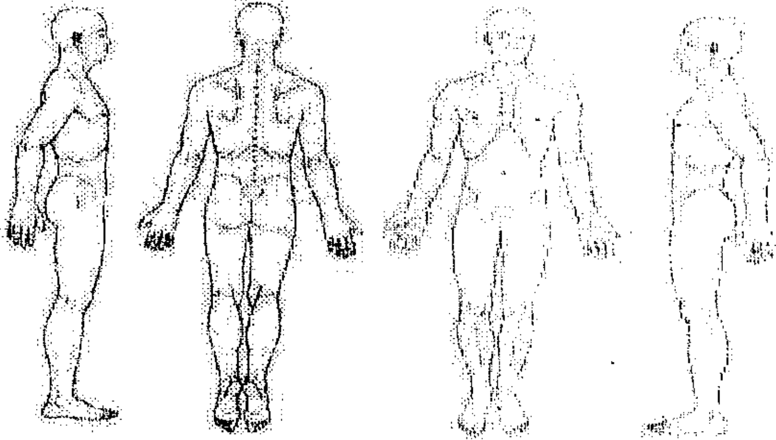
a. When did your symptoms start? ______________________

b. How did your symptoms begin? ______________________

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

① No One ② Chiropractor ③ Medical Doctor ④ Physical Therapist ⑤ Other

a. What treatment did you receive and when? ______________________

b. What tests have you had for your symptoms and when were they performed?

① Xrays date: ________ ③ CT Scan date: ________
② MRI date: ________ ④ Other date: ________

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office ② Chiropractor ③ Medical Doctor ④ Physical Therapist ⑤ Other

10. What is your occupation?

____

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

Patient Signature ______________________ **Date** ______________