For Office Use:

STAFF:

Policy

PATIENT REGISTRATION FORM

Name: ____ Date: _______________
Address____________________________________ Apt#_____ Date of Birth___________
City_____________________________ State_____ Zip Code______________________
Sex: M F HOME# (___) _______________ CELL# (___) _______________
Marital Status: [S] [M] [D] [W] [Sep.] Social Security#___________________________
Employer__________________________ Address________________________________
Work# (____) _______________________ Occupation______________________________
Have you had Physical therapy this year? Yes___ No___
How many visits did you use? _______

E-Mail Address: ____

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**_________

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 $50. 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 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 $50 will be charged for each no-show and cancellation made less than 12 hours of the scheduled appointment. Insurance companies do not pay for no-show "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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____

Patient's Signature: ____________________________________ Date____________________

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

<u>OSHMAN & BARTECK PT NOTICE OF PATIENT INFORMATION PRACTICES</u>

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 disclosure of 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 165 West 46th St Suite 909 New York NY 10036
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
vers112008

<u>Important Cancellation Policy</u>

<u>A fee of $50 will be charged for no-shows and cancellations made less than 12 hours prior to your scheduled appointment.</u>

Insurance companies do not pay for no-show "visits." An appointment cancelled last minute also prevents other patients from being treated at that time. Cancellations made at least 12 hours in advance will give us enough time to schedule others who may have wanted that appointment. After two infringements of our policy, you will be considered for discharge from our service.

We advise you schedule appointments at least one week in advance to help us 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.

Please write your initials next to the following conditions:

a. ____ A $50 FEE will be charged if you cancel <u>less than 12 hours</u> prior to your appointment or

b. ___ A $50 FEE will be charged if you fail to inform of us of a cancellation (no-show).

By initialing above and signing below, you acknowledge that you have read and understood our cancellation policy.

____Date______________________
Patient Name

____Date______________________
Signature