Zion PHYSICAL THERAPY NEW YORK CITY

Patient Information

OFFICE USE ONLY

pt name _____

IE PT: _____

RX ____ DX _____

BCBS UHC OX CG AT SP MCR

Ref _____

Welcome to our Practice, our Team looks forward to working with you towards your healthy living goals! Please take a few minutes to confirm your primary patient information and familiarize yourself with the Zion PT Practice & Financial Policies.

Date: _____

Last Name: _____ First Name: _____

Gender: F M Birth Date: _____

Street: _____

Apt:____ City: _____

State: _____ Zip: _____

Primary Phone: _____ Work Phone: _____

Cell: _____

E-mail: _____

Whom may we thank for referring you to us? _____

Primary Insurance Information:

Insurance Company Name: _____

ID #: _____ Group #: _____ ☐ Card scanned in Drive

Policy Holder: SELF or First/ Last name:_____

Policy Holder's Date of Birth: _____ Relationship to Patient:_____

Provider Phone #: _____

Secondary Insurance Information, if applicable

Insurance Company Name: _____

ID #: _____ Group #: _____ ☐ Card scanned in Drive

Policy Holder: SELF First/ Last name:_____

Policy Holder's Date of Birth: _____ Relationship to Patient:_____

Provider Phone #: _____

General Medical History

Please check the box if you have experienced the following:

- ☐ DIABETES
- ☐ PACEMAKER
- ☐ HIGH BLOOD PRESSURE
- ☐ BONE DISEASE
- ☐ CHRONIC HEADACHES
- ☐ KIDNEY PROBLEMS
- ☐ NERVOUS DISORDERS
- ☐ HERNIA
- ☐ PINS & NEEDLES
- ☐ FRACTURES (BROKEN BONES)
- ☐ CIRCULATORY DISEASE
- ☐ BLADDER IRREGULARITIES
- ☐ BOWEL IRREGULARITIES
- ☐ CHEST PAIN/HEART PALPITATIONS/SHORTNESS OF BREATH
- ☐ BALANCE/COORDINATION
- ☐ FOOD AND/OR DRUG ALLERGIES
- ☐ SENSITIVITY TO COLD
- ☐ SENSITIVITY TO HEAT
- ☐ ALLERGIES
- ☐ PREVIOUS SURGERY
- ☐ SEIZURES
- ☐ METAL IMPLANTS
- ☐ DIZZINESS
- ☐ CANCER
- ☐ PROSTATITIS
- ☐ OSTEOPOROSIS
- ☐ CYSTITIS
- ☐ RECENT WEIGHT LOSS
- ☐ VASCULAR DISEASE
- ☐ OTHER
- ☐ SMOKING

If you checked any of the above, please explain:

_____

_____

Please list any current medications and for what condition:

_____

_____

HIPAA: Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can gain access to this information

Your Rights:

• You can ask to see or obtain an electronic or paper copy of your medical record

• You can ask us to correct health information about you that you think is incorrect or incomplete.

• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address than the one listed as your primary.

• You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.

• You can ask for a list of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.

• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

• You can complain if you feel we have violated your rights by contacting us. You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/ privacy/hipaa/complaints/.

• *If you are not able to tell us your preference about sharing your information, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

• We never share your information for marketing purposes and sale of your information unless you give us written permission

We typically use or share your health information in the following ways:

Treat you*: We can use your information and share it with other professionals who are treating you. Ex: A doctor treating you for an injury asks us about your overall health condition.*

Run our organization*: We can use and share your health organization information to run our practice, improve your care, and contact you when necessary. Ex: We use health information about you to manage your treatment and services.*

Bill for your services: *We can use and share your health information to bill and get payment from health plans or other entities. Ex: We give information about you to your health insurance plan so it will pay for your services*

HIPAA: Notice of Privacy Practices (cont)

Our Responsibilities

• We are required by law to maintain the privacy and security of your protected health information.

• We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

• We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you give us permission in writing. If you do, you may change your mind at any time.

HIPAA Privacy Authorization Form

☐ I understand my rights as a patient as well as the responsibilities of my healthcare provider, as explained above.

☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse)

Extent of Authorization: I authorize Zion Physical Therapy to use and disclose the protected health information described herein to

_____(Your medical doctor)

This authorization for release of information covers all past, present, and future periods.

_____
Please print your name

_____ _____
Signature Date

Patient refused to sign (staff initial required) ☐