PARK AVENUE
Physical Therapy & Wellness

PATIENT HIPPA AWARENESS AGREEMENT

A copy of the Notice of Privacy Practices was made available to me prior to signing this consent. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information.

The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following: treatment, payment, and health care operations.
- A description of each of the purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- a description of uses and disclosures that are prohibited or materially listed by law.
- a description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  - The rights to complain to this practice if I believe my privacy right has been violated, and that no retaliatory actions will be used against me in the event of usch complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

The practice reserves the right to change the terms of Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

_____ _____ / _____ / _____
Signature of Patient or Legal Guardian Date

_____ _____ / _____ / _____
Print Patient's Name Date

_____ _____ / _____ / _____
Print Legal Guardian's Name Date

Huntington: 175 E Main Street, Suite 110 Huntington, NY 11743 (631) 427-7600
Northport: 10 Fort Salonga Road, Suite 2A Northport, NY 11768 (631) 343-9194

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PATIENT REGISTRATION FORM

Last Name: _____ First Name: _____ MI:____

Address: _____ D.O.B: _____ Sex: M/F

City: _____Zip Code: _____ Referring Physician: _____

Phone: Home: _____ Cell: _____ Email: _____

Work: _____ Ext.: _____ Preferred Method of Contact: Home Cell Work

(Circle One)
Marital Status: Married Single Divorced Widowed Domestic Partner

Employment Status: Employed FT/PT Retired Student Other: _____

Employer Name: _____

Guarantor: __Y ___N If no Name: Last: _____ First: _____

Emergency Contact Name: _____ Phone: _____

Primary Insurance Information: Please Provide Your Insurance Cards to The Receptionist

Company: _____ Secondary Insurance Company: _____

POLICY HOLDER INFORMATION: SELF: _____Y _____N

If No, Policy Holder: Last Name: _____ First Name: _____ MI: ___

Employer: _____ Date of Birth: _____

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do agree and give my consent for Park Avenue Physical Therapy & Wellness, to furnish the medical care and treatment considered necessary and proper in assessing or treating _____'s physical and mental condition.

Patient/Guardian: _____ Date: _____

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Patient Intake Form

Patient Name: _____ Age:_____ Height: _____ Weight: _____

Chief Complaint: _____

History of Injury: _____

Surgery: ____No ____Yes If Yes: Date:_____ Type:_____

Limitations: _____ Self Care _____ Carrying, Moving Objects ____Mobility Walking & Moving Around _____ Changing & Maintaining Body Position

Pain Scale: 0=None 5=Moderate 10=Extreme

Current: 0 1 2 3 4 5 6 7 8 9 10 At Worst: 0 1 2 3 4 5 6 7 8 9 10

At Best: 0 1 2 3 4 5 6 7 8 9 10 Pain: Sharp / Dull / Achy / Burning / Throbbing

What makes it worse? _____

What makes it better? _____

Occupation/Work Status: ____Student ____Working ____Retired ____Other: _____

Medical History:

Previous Treatments for Similar Sypmtons: ___Yes ___No ***If yes, please explain:*** _____

_____

____ No Known Significant previous medical history to affect treatment

____Alzheimer's ___Parkinson's ___Lupus ___History of Cancer: _____

____Cardiovascular Disease: ___Pacemaker ___Atrial fibrillation

___Multiplce Sclerosis ___Osterarthritis ___Rheumatoid Arthritis ___Diabeter ___Type1 ___Type 2

Fibromyalgia ___Other: _____

Current Medication & Dosages: _____

_____

Diagnostic Testing: ___X-Ray ___MRI ___CT-Scan ___EMG

Surgical History: _____

Patient Goals: _____

Patient/Guardian Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

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Pain Disability Index

Pain Disability Index: We would like to know how much pain is preventing you from doing what you would normally do or from doing it as well as you normally would. These ratings measure the degree to which aspects of your life are disrupted by chronic pain.

Please circle the number on the scale that describes the level of disability you typically experience during each life activity. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

Family/Home Responsibilities: Refers to chores or duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g. driving the children to school).

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Recreation: Refers to hobbies, sports, and other similar leisure time activities.

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Social Activity: Refers to activities which involve participation with friends and other family members. It includes, parties, theater, concerts, dining out, and other social functions.

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Occupation: Refers to activities that are part or directly related to one's job.

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Self Care: Independent daily living (e.d. taking a shower, driving, getting dressed, etc.)

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Life-Support Activities: Refers to basic life supporting behaviors such as eating, sleeping and breathing.

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Signautre: _____ Date: _____

Print Name: _____

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Cancellation Policy

Our goal is to provide quality health care to all of our patients in a timely manner. No-shows, late arrivals, and cancellations inconvenience not only our providers, but our other patients as well. Please be aware of our policy regarding missed appointments.

Appointment Cancellation
When you book your appointment, you are holding a space on our calendar that is no longer available to other patients. In order to be respectful of your fellow patients, please call the office as soon as you know you will not be able to make your appointment.

If cancellation is necessary, we require you call at least 24 hours in advance. Appointments are in high demand, and your advanced notice will allow another patient access to that appointment time. If you do NOT cancel within 24 hours, you will be responsible for a $25 cancellation fee.

If a patient is more than 15 minutes late for an appointment, Park Avenue Physical Therapy & Wellness reserves the right to cancel the appointment and charge a $25 late cancellation fee.

Late Cancellations/No-Shows
A cancellation is considered late when the appointment is cancelled less than 24 hours before your scheduled appointment time. A No-Show will automatically be charged the fee.

Should a patient miss two consecutive appointments without calling to cancel, you will be removed from the master schedule and forfeit all further permanent appointments.

COVID Cancellations
Any appointment that is cancelled due to COVID requires proof of testing results.

I have read and understand the cancellation policy. I understand that I will be responsible for the cancellation fee if I do not adhere to the policies.

Patient Name: _____

Patient Signature: _____ Date: _____

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ALL INFORMATION BELOW IS REQUIRED FOR CANCELLATION POLICY.
KINDLY PRINT LEGIBLY.

Credit Card Type: (Choose One)

MASTERCARD VISA DISCOVER CARD

AMERICAN EXPRESS

Cardholder's Name: _____

Credit Card Number: _____

Expiration Date: _____ / _____

Security Number: _____

Patients Signature: _____ Date: _____

****Information is kept Secure and Confidential**

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