

PERFORMAX PHYSICAL THERAPY & REHABILITATION P.C.

WRITTEN ACKNOWLEDGEMENT OF PRIVACY NOTICE

I have received the Performax Physical Therapy & Rehabilitation P.C. Privacy Notice. My signature does not indicate that I have read, understood, or agree with the Notice, only that it has been provided to me.

Signature of Patient/Parent/Legal Guardian

Date

Relationship to Patient (if not the patient)

Documentation of Good Faith Effort

Attempted to distribute the Privacy Notice to the patient/parent/legal guardian, but the patient/parent/legal guardian declined to acknowledge the receipt of the Privacy Notice.

Performax Physical Therapy & Rehabilitation Employee

Date

Explanation: _____

Printed Patient Name:

Last, First, MI

Medical Account Number

PERFORMAX PHYSICAL THERAPY AND REHABILITATION P.C.
Informed Consent

Authorization for Treatment: I authorize the treating physical therapist at Performax Physical Therapy and Rehabilitation P.C to administer any necessary treatment including but not limited to evaluations and diagnostic procedures, application of modalities, manual therapy and prescription of therapeutic exercise.

Release of Health Information: I authorize release of my medical information to my referring physician and the staff at Performax Physical Therapy and Rehabilitation P.C. as outlined in the Privacy Notice provided to me. I also authorize release of my health information to my insurance carrier/third-party payor as deemed necessary.

Assignment of Benefits: I/we assign benefits and authorize payment to Performax Physical Therapy and Rehabilitation P.C. for treatment and services rendered.

Patient Responsibility: I understand that I am financially responsible for any charges not covered by my insurance carrier, including but not limited to medical deductibles, co-payments, and co-insurance. I understand that all co-payments are due at the time of service. If billed for payment, I agree to pay the balance owed within 30 days from the billing date.

I understand that I am responsible for payment of services and procedures which are not covered by my insurance carrier.

CANCELLATION / NO SHOW: I understand that I will be responsible for a \$25 fee, not covered by my insurance carrier, for all appointments not cancelled within 24 hours of my scheduled appointment time.

Patient's Printed Name: _____

Patient's Signature: _____ Date: _____

Signature of Parent or Legal Guardian, if a minor: _____

Relationship to Patient: _____

IN CASE OF EMERGENCY, WHO SHOULD WE CONTACT?	
Name	Relationship
Address	City, State, Zip
Daytime Phone #	Evening Phone #

PERFORMAX PHYSICAL THERAPY & REHABILITATION, P.C.

PATIENT INFORMATION

Patient Name	M F	Date of Birth
Address	City, State, Zip	
Home Phone #	Work Phone #	
Cell Phone #	Marital Status	
Social Security Number	Email Address – May we contact you with health information? Y N	
Referring Physician	Diagnosis or Chief Complaint	
Date of Injury or Accident	Related to auto accident or employment	
How did you hear about facility?		

INSURANCE INFORMATION

PRIMARY INSURANCE	Claim or ID #
Subscriber Name	Group #
Subscriber DOB	Subscriber Employer
Ins Billing Address	Ins Phone #
SECONDARY INSURANCE	Claim or ID #
Subscriber Name	Group #
Subscriber DOB	Subscriber Employer
Ins Billing Address	Ins Phone #

Appointment Date & Time: _____ Therapist: _____

Performax Physical Therapy and Rehabilitation, P.C.
Medical History

Name: _____

Date of Birth: _____

Please check below if you currently have or have a history of the following:

- | | | |
|--|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Metal implants |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Asthma | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Epilepsy/seizures | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Latex allergy | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Current pregnancy | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Arthritis | |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke | |

Please list any surgical procedures with dates:

Please list all medications you are currently taking:

List any allergies:

List any hobbies, sports, recreational activities:

How did you hear about Performax?

Do you currently exercise? Yes No

Do you smoke? Yes **How much?** _____ No

Do you work? Yes No **What is your occupation?** _____

Are you currently under the treatment of a chiropractor? Yes No

Have you previously sought treatment for this condition? Yes No

Have you had physical therapy this year? Yes No

Please describe your goals in attending physical therapy:

Patient's Signature _____ Date: _____

Parent's Signature (if minor) _____ Date: _____

**PRIVACY NOTICE FOR
PERFORMAX PHYSICAL THERAPY AND REHABILITATION P.C.**

Performax Physical Therapy and Rehabilitation P.C. is required by law to protect the privacy of patient's health information. This Privacy Policy explains what information we collect, how this information will be used and how we protect the security and confidentiality of your information.

Collection of Health Information:

We collect and retain all information necessary in the provision of physical therapy services. This includes but is not limited to physician referral, insurance information, medical history, completion of initial evaluation, progress notes and discharge summaries.

Disclosure of Health Information:

We may not utilize or disclose health information regarding treatment, insurance reimbursement, and administrative operations without your consent, unless otherwise mandated by New York State law, or for payment of treatment by your insurance carrier. In such case, we will obtain written permission from you to disclose your health information.

All treatment information gathered by your physical therapist will be maintained in your patient chart and utilized to determine a plan of care. Health care staff at Performax Physical Therapy and Rehabilitation P.C. will review and discuss your record as needed in order to devise a plan of care and carry out treatment protocols. We will provide your referring physician with a copy of your initial evaluation, progress reports, and discharge summaries in order to establish the best plan of care. We may disclose health information pertaining to diagnosis and evaluative measurements, treatment, and utilization of therapy supplies to your insurance carrier for authorization and reimbursement purposes.

We may not disclose your location or general health information to a family member, guardian or other persons responsible for your care. Disclosure of specific health information will require your signature prior to release of information.

We may disclose health information as permitted by law in the case of subpoena, court order, judicial proceedings or other binding authority.

You have been provided this notice of privacy policies for informational purposes. We reserve the right to amend this policy at any time.

Patient Rights

You have the right to review or obtain a copy of your health information at any time. We reserve the right to charge you a cost-based copy fee, according to the Public Health Laws. Should this record obtain inaccurate or incomplete information, you have the right to make a written request that a correction be made. All requests are a part of your permanent patient file.

If you have questions, would like additional information, or you believe your privacy rights have been infringed upon, please contact our Privacy and Security Officer, or a written complaint can be filed with the U.S. Department of Health and Human Services.

Privacy & Security Officer
Dana Sullivan, MSPT
Performax Physical Therapy & Rehabilitation P.C.
40 Saw Mill River Road
Hawthorne, NY 10532