Physical & Occupational Therapy & Acupuncture, PLLC
87-09 Justice Avenue, Elmhurst, NY 11373 Tel: (718) 699-5070
2 Hope Drive, Plainview, NY 11803 Tel: (516) 822-2118
Fax: (718) 699-5071

PATIENT REGISTRATION FORM

Name (Last, First): _____

Date of Birth: ___ /___ / _____

Gender: Male __ Female __

Address: _____ Apt. _____

City _____

State _____ Zip Code _____

Home Phone: ( ) _____

Cell/Work: ( ) _____

Email: _____

Occupation_____

Employer: _____ Phone: _____

Social Security No.: _____

Driver's License No.: _____

Marital Status: Single __ Divorce __
Married __ Other __

Emergency Contact: _____

Relation: _____

Phone No.: _____

Primary Care Physician: _____
Tel: ( ) _____
Referral Physician: _____
Tel: ( ) _____

INSURANCE INFORMATION

Primary Insurance
_____
Policy No. _____
Group No. _____
Company Name _____
Relationship to insured:
☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Holder (If other than self)
_____
Date of Birth ___ / ___ / ___

Secondary Insurance: _____
SSN _____
Policy No.:_____

INSURANCE AND PAYMENT AGREEMENT

You have the right for all insurance terms and policies to be explained to you prior to beginning treatment. Medicare beneficiaries should be aware that there is a Medicare "**CAP**" which limits patients to approximately 15 physical/occupational therapy visits per calendar year. However, there are some circumstances where this "**CAP**" can be exceeded. As a patient of Stellar Physical & Occupational Therapy & Acupuncture, PLLC, you hereby authorize those payments of medical insurance benefits to be made payable to Stellar Physical & Occupational Therapy & Acupuncture, PLLC for physical/occupational therapy and/or Acupuncture services provided. You are also hereby authorizing Stellar Physical & Occupational Therapy & Acupuncture, PLLC to use a copy of your benefit assignment in place of the original. This copy is to be considered as valid as the original. You are also responsible for the following:

- Providing Stellar Physical & Occupational Therapy & Acupuncture, PLLC with all necessary insurance information;
- Notifying Stellar Physical & Occupational Therapy & Acupuncture, PLLC of any changes in your insurance policy or coverage prior to your next appointment;
- Notifying Stellar Physical & Occupational Therapy & Acupuncture, PLLC of any service or treatment (nursing, physical therapy, occupational therapy, etc.) provided to you in your home by a Home Health Agency or any other facility;
- Notify Stellar Physical & Occupational Therapy & Acupuncture, PLLC of any cancellation 24 hours prior to your scheduled appointment. Failure to do so will result in you being charged 75% of your session fee.

Consent for Care and Treatment

I, the undersigned do hereby agree and give my consent and permission for Stellar Physical & Occupational Therapy & Acupuncture, PLLC to furnish the medical care and treatment considered necessary and proper in assessing or treating (name_____'s physical and mental condition.

I further authorize all holders of medical information to release upon request any information deemed necessary for Stellar Physical & Occupational Therapy & Acupuncture, PLLC to file a medical claim.

Benefit Assignment/Release of Information

I hereby assign all medical benefits to which I am entitled, including the ones from Medicare, Medicaid, private insurances and third party payers to Stellar Physical & Occupational Therapy & Acupuncture, PLLC. In doing so, I release Stellar Physical & Occupational Therapy & Acupuncture, PLLC from any and all legal liability that may arise from the release of such information. I agree that a copy of this authorization may be used in place of the original, and this copy is to be considered as valid as the original.

The above information has been read and explained to me. I understand my responsibility for the payment of my account.
I acknowledge that I have received and read the policies disclosed in Stellar Physical & Occupational Therapy & Acupuncture, PLLC Rights and Privacy form. In addition, I have read and consent to all of the above insurance and payment policies of Stellar Physical & Occupational Therapy & Acupuncture, PLLC.

Patient/Guardian Signature: _____ **Date: _____**

REFERRAL SOURCE: DOCTOR:_____ FRIEND: _____ OTHER: _____

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Patient HIPPA Awareness Agreement

With my permission, Stellar Physical & Occupational Therapy & Acupuncture, PLLC may use and disclose protected health information about me to carry out treatment, payment and healthcare operations.

With my permission, the office or representative of Stellar Physical & Occupational Therapy & Acupuncture, PLLC may call my home or other designated locations and leave a message on voicemail or with a person in reference to any item(s) that may assist the practice in carrying out necessary healthcare operations, such as appointments, reminders, insurance matters and any information pertaining to billing and collections or my medical care, including laboratory results and prescriptions among other health care or administrative matters.

With my permission, the office or representative of Stellar Physical & Occupational Therapy & Acupuncture, PLLC may mail to my home or other designated locations any items that may assist the practice in carrying out healthcare operations related to me, such as appointment reminders and patient statements as long as they are marked Personal and Confidential. Stellar Physical & Occupational Therapy & Acupuncture, PLLC is not to be held responsible for any damages that may be caused by an unauthorized person attaining such information without my consent. I have the right to request that Stellar Physical & Occupational Therapy & Acupuncture, PLLC restrict how it uses or discloses my personal health information to carry out healthcare operations. However, Stellar Physical & Occupational Therapy & Acupuncture, PLLC or its representative reserve the right to decline my request, though if it does agree it is bound by this agreement.

By signing this form, I am allowing Stellar Physical & Occupational Therapy & Acupuncture, PLLC to use and disclose my personal health information for my treatment, payment and other reasonable healthcare operations.

I may revoke my consent in writing for further disclosures except to the extent of any and all information that Stellar Physical & Occupational Therapy & Acupuncture, PLLC has already disclosed in reliance upon my prior consent.

_____ Date: _____
Signature of Patient or Legal Guardian

_____
Print Patient's Name

Name (Last, First): _____ Gender: Male / Female

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Date of Birth: ___ /___ / _____ **Exam Date: _____**

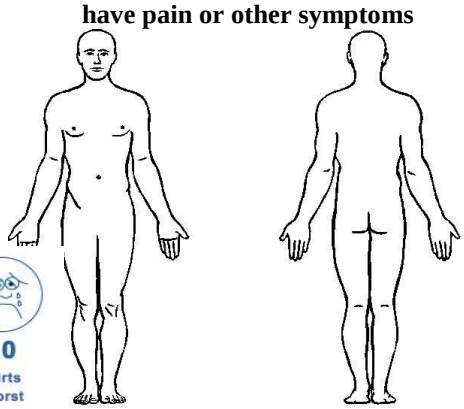
Medical Condition Form

Describe Your Current Problem, How It Begin and How long

_____
_____
_____

Onset Date/Surgery Date _____

Indicate 'X' below where you have pain or other symptoms



Is your condition due to An accident__ Work __ Other _____

How often are you symptoms present?

_ **Constantly** (76-100 % of the day) _ **Occasionally** (26-50 % of the day)
_ **Frequently** (51-75 % of the day) _ **Intermittently** (0-25 % of the day)

Describe the nature of your pain:

_ Sharp _ Dull Ache _ Numb _ Tingling _ Shooting
_ Burning _ Localized _ Radiating

How is your condition changing?

_ Getting Better _ Not Changing
_ Getting Worse

Current complain (how you feel today): circle it

[_____]

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Unbearable Pain**

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores)?

[_____] **Unable to carry on any activities**

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

In general would you say your overall health right now is:

_ Excellent _ Very Good _ Good _ Fair _ Poor

Have you had X-Rays, MRI, CT Scan for your area(s) of complaint: _ Yes _ No

Date(s) taken _____ What area(s) were taken? _____

Please check all of the following that apply to you:

_ Asthma
_ Anemia
_ Cardiac Condition
_ Pacemaker
_ Stroke (Date) _____
_ High Blood Pressure
_ High Cholesterol
_ Surgeries _____

_ Diabetes _ Type 1 _Type 2
_ Hepatitis ____
_ Osteoporosis _ Arthritis
_ Kidney Disease
_ Urinary Problems
_ Cancer/Tumor_____
_ Recent Fever

_ Numbness (Location) _____
_ Dizziness/Fainting
_ Pain at Night
_ Pain Unrelieved by Position or Rest
_ Currently Pregnant, # weeks _____
_ Abnormal Weight _ Gain _ Loss
_ HIV/AIDs
_ Other _____

Smoking __ (__ cigarettes __ packs per day**)** **Alcohol __ (** _ Social Drinker_ Heavy Drinker) **Weight:** _____ **Height:** _____

Current Medications:_____
_____

Who have you seen for your condition before today?

_ No One _ Medical Doctor _ Massage Therapist _ Chiropractor _ Physical Therapist _ Other_____

Major Hospitalization: _____ Drug Allergies: _____

Patient Signature: _____ Today's Date: _____