Name _____ Date____/____/_____

Date of Birth___/___/____ Social Security Number____-___-____ Gender : M / F

Address_____

Home Telephone (____)_____ Cell Phone (____)_____

Email Address_____

Emergency Contact Name and Phone Number:

_____

The best way to communicate with you between visits (circle one):

Email Cell Home

Please be aware that email is not always a secure way of communicating and that any emails do become a part of your medical record.

May we discuss your private medical information with you via email? ____Yes ____No

**INSURANCE INFORMATION:**

Primary Insurance:

Insurance Carrier_____

Policy #_____ Group #_____

Secondary Insurance:

Insurance Carrier _____

Policy # _____Group #_____

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(917)439-1276 Rob@VecsiPT.com

Do you have a prescription? ____Yes ____No

Condition to be treated_____

Have you have been treated for any of the following:
(Please circle all that apply)

| | | | |
|---|---|---|---|
| Heart Disease | Diabetes | High Blood Pressure | Epilepsy |
| Cancer | Tuberculosis | Visual Impaired | Fibromyalgia |
| HIV / AIDS | Arthritis | Hearing Impaired | Scoliosis |
| Stroke | Asthma | Latex Allergy | Other |
| Osteoporosis | Hepatitis | Pacemaker | |

Other_____

Have you had surgery for your condition? Y/ N Date:_____
Is condition related to auto accident? Y / N Date:_____
Is condition related to non-work accident? Y/ N Date:_____
Is condition related to work accident? Y / N Date:_____
Have you had any injections for your condition? Y / N Date: _____

Please list any diagnostic tests you have had for this condition:
_____

Please list any medications that you are taking:
_____

What are your current symptoms? _____

How the injury or problem occurred? _____

Please rate your pain using a 0 – 10 scale (0 = no pain, 10 = the worst pain you can imagine):

Worst pain since onset: _____ Best pain since onset: _____ Today's pain:_____

Where is your pain or problem located?_____

Is your pain? Constant Intermittent Dull Sharp Other _____

What makes your pain / problem better? _____ Worse? _____

Is there pain present at night? Y / N What position helps you sleep? _____

Have you had PT for this condition? Y / N If Yes where? _____

Have you had chiropractic services for this condition? Y/ N If yes where? _____

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**Employment History:**

Are you currently working? Y / N  If no how many total days of work have you missed? ____

Are your work duties?  Full  Restricted  How many hours a week do you work? _____

Who is your employer? _____

What type of work do you do? _____

What activities in your daily life or work duties have been most affected by your problem?

_____

What do you hope to accomplish with therapy?

_____

Are you exercising at home?  Y / N  If yes, what type? _____

Are you using heat or cold?  Y / N  If yes, what type? _____

Are you wearing a sling or brace?  Y / N  If yes, what type? _____

Do you smoke?  Y / N  If yes, how much? _____

What type of non-work activities are you involved in? _____

When are you scheduled to see your doctor again? _____

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## Notice of Privacy Practice

**Effective date: January 1, 2014**

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), this notice describes how health information about you as a patient of this practice may be used and disclosed and how you can get access to your protected health information.

**A.** Our practice is dedicated to maintaining the privacy of your protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time. The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices.

**B.** Intake forms including demographic date, insurance information, consents for treatment and medical disclosure will be completed by every patient as part of his/her record. Our office may use and disclose this PHI in order to bill and collect payment for the services you receive from us.

**C**. Employees and staff are required to sign a confidentiality agreement regarding any information they are exposed to in the office setting which is not to be discussed or revealed to any persons or businesses outside of the office setting without the prior written consent by the patient or legal guardian.

**D.** Any paper trash with patient information will be shredded prior to discarding it.

**E.** Medical release forms are required to be signed by the patient or legal guardian in order to release any medical information to themselves, medical offices, insurance companies, or to any other desired location. There may be a reasonable cost-based fee for photocopying, postage and preparation.

**F.** Our office may contact you for appointment reminders and announcements about our office and staff.

Patient's Printed Name:_____

Patient's Signature:_____ Date:_____

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**Acknowledgements: (Please initial)**

_____ I verify that the information I provided about my health concern is complete and truthful to the best of my knowledge.

_____ I hereby consent to and authorize Robert Vecsi  Physical Therapy LLC to perform aphysical therapy . Treatment may include any required examination, diagnostic test, or rehabilitation techniques.

_____ I may request a copy of the Notice of Privacy Practices for the office. I understand how my information will be used and disclosed.

_____ I understand that any insurance I may have is an agreement between the insurance carrier and me. I acknowledge responsibility for the payment of any covered or non-covered services I receive.

_____ I understand that I am responsible for any co-insurance fees and that they are to be paid at the time of service.

_____ I understand that should I cancel with less than 24 hours notice I will owe a $75 cancellation fee unless it was a medical emergency. (irst time canceallation fee will waived)

_____ I give my consent for Robert Vecsi Physical Therapy LLC and staff to bill my insurance for services provided.

I have had the opportunity to read this form, the Notice of Privacy Practices, and understand the Office Financial Policies.  My questions have been answered to my satisfaction.

_____

Patient Name (Please Print)

_____

Signature of Patient Date

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