MICHELLE RODRIGUEZ
PHYSICAL THERAPY & WELLNESS

PATIENT INTAKE FORM

All sections of the **Patient Intake form** MUST be filled out before your treatment with a practitioner.
I,_____ verify that all information is correct and complete.
Please intial here:_____

Patient Name:_____ Date: ___ /___ / 20__

Address:_____ City: _____ State: _____ Zip Code: _____

Home Telephone: ____ - ____ - ____ Mobile Phone Number: ____ - ____ - ____

Social Security Number: ____ - ____ - ____ Date of Birth: ____ / ____ / ____

Occupation: _____ E-Mail Address: _____ @ _____

Employer Name: _____

Employer Address: _____ City: _____ State: _____ Zip Code: _____

Referral Source: _____

Emergency Contact: _____, ____ - ____ - ____
Name Phone Number

Please initial on the lines below.

_____ **CONSENT TO TREAT A MINOR.** If the "Patient" is under the age of 18 years old. I authorize Michelle Rodriguez Physical Therapy & Wellness, to administer reasonable and standard physical therapy evaluations, and treatments to the "Minor Patient," even if I am absent.

_____ **ASSIGNMENT AND RELEASE OF INFORMATION STATEMENT.** I certify that the information I provided is correct. I authorize releasing any information related to my medical care, as requested by government agencies and/or insurance carriers. I hereby assign benefits to Michelle Rodriguez Physical Therapy & Wellness. In the absence of accepted insurance coverage, I/legal guardian am responsible for full payment of services rendered.

_____ ____ / ____ / 20____
Patient or Patient Guardian's Signature Date

Michelle Rodriguez Physical Therapy & Wellness
130 West 56th Street, 3rd Floor, New York, New York 10019 PH: (212) 247-8436 FAX: (877) 839-2129

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Thank you for taking the time to provide us with the information on the **Patent Intake Form**. Your answers help us understand your condition, provide the best care possible, and meet the high standards we believe in at Michelle Rodriguez Physical Therapy & Wellness.

Current Condition:

Describe, in your own words, why you are seeking treatment today: _____

_____

_____

_____

_____

How long have you had this condition? _____

What makes your condition feel better? _____

What makes your condition feel worse? _____

Have you been given a medical diagnosis for this condition? **Yes / No** If so, what is it? _____

_____

What is your level of hopefulness that your current condition is going to improve? (Not at all) **0 1 2 3 4 5 6 7 8 9 10** (Most Hopeful)

Have you had any imaging? **Yes / No** : **X-Ray MRI CAT MRI Ultrasound Other**:_____

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Pain Diagram

(Please mark your areas of injury or discomfort on the chart below)

Numbness

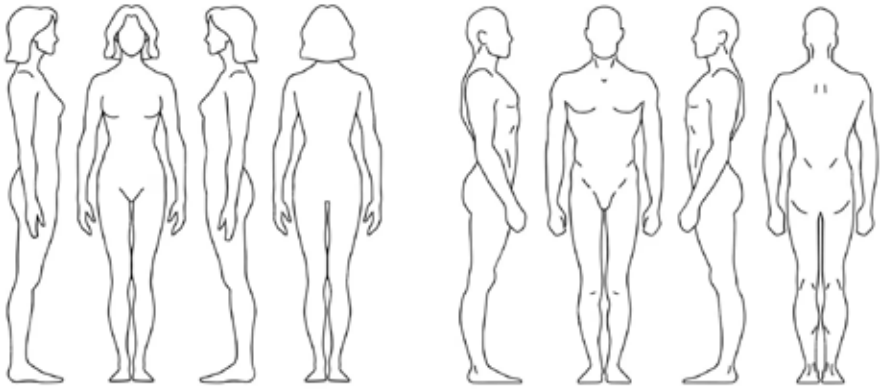
Pins & Needles

Burning

Aching

Stabbing

Circle description of your pain



Additional comments on pain: _____

_____

_____

_____

Have you had any previous treatment for the condition you are here for today? **Yes / No**

If Yes, please explain: _____

_____

General Health

Do you feel fatigued or often find it difficult to get through the day due to low energy levels? **Yes / No**

How many hours of sleep, on aveage do you get per day? _____

Are you sensitive to pressure on your muscles, or find that you are easily irritate or inflamed? **Yes / No**

Do you smoke? **Yes /No** If Yes, how much per day? _____ per week? _____

Do you drink Alcohol? **Yes / No** If Yes, How many drinks per day? _____ per week? _____

What is your overall stress level? (no stress) **0 1 2 3 4 5 6 7 8 9 10** (100% stress)

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Credit Card Authorization Form

I, _____ authorize Michelle Rodiguez Physical Therapy to charge my Credit Card

AMEX / Visa / Mastercard / Discover: _____
Please Circle Credit Card Number

___ / ___ / 20____ _____ _____-_____
Expiraton Date Security Code Billing Zip Code

Terms & Conditions

Michelle Rodriguez Physical Therapy & Wellness puts the credit card information on file.

This applies to late cancellations, missed appointments, and cases when the payment method cannot be presented in person.

Michelle Rodriguez Physical Therapy & Wellness agrees to notify you by email or phone before charges.

_____ ____ / ____ / 20__
Signature Date

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Direct Access Phyiscal Therapy

New York State passed a law in 2006 allowing Physical Therapists to provide care directly without a prescription for a limited number of visits. The law limits treatment to **ten (10) visits** or **thirty (30) days** from the initial visit, whichever comes first. The law also stipulates that ONLY Physical Therapists practicing physical therapy on a full-time basis equivalent to not less than **three (3) years** can deliver care under Direct Access Phyiscal Therapy.

A physician, dentist, podiatrist, nurse practitioner or midwife can make referrals for physical therapy.

Direct Access Physical Therapy **MAY NOT** be covered by your Health Care Plan and/or insurer without a **Referral**, but it may be a covered expense with a **Referral**.

New York State law requires Michelle Rodriguez Physical Therapy to provide you with this information.

I have read and understand the above information.

_____ _____/_____/ 20___
Patient's Signature Date

_____ _____/_____/ 20___
Patient's Guardian Signature Date
(If Patient is under 18 years old)

_____ _____/_____/ 20___
Physical Therapist Signature Date

The Patient MUST BE given a signed copy of the Direct Access Physical Therapy document, and Michelle Rodriguez Physical Therapy MUST BE keep a copy with the patient's medical records.

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No-show / Late Cancellation Policy

Your appointment time is significant to us as it is set aside expressly for you.

If you need to cancel an appointment, we require at least **forty-eight (48) hours' notice** or **before 5:00 p.m. on Friday if the cancellation is on a Monday.** If we **DO NOT** get at least **forty-eight (48) hours' notice** or **notice by 5:00 p.m. on the Friday before a Monday appointment**, we may not be able to schedule another patient who may need that time slot. In such an event, you **WILL** be charged for a late cancellation or "no show," Michelle Rodriguez Physical Therapy will charge the full treatment fee directly to you.

Health Care Plans and/or Insurance carriers WILL NOT PAY for missed visits.

I have read and agree to abide by the No-Show/Late Cancellation Policy.

_____ ____/____/ 20___

Patient's Signature Date

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

How Michelle Rodriguez Physical Therapy & Wellness may use or disclose your Protected Health Information (PHI)

Treatment, Payment, and Health Care Operations

In most cases, Michelle Rodriguez Physical Therapy & Wellness may use and disclose **Protected Health Information** (PHI) for treatment, payment, and healthcare operations without your written permission.

Treatment refers to providing, coordinating, or managing healthcare and related services by one or more healthcare providers. For example, as a healthcare provider, Michelle Rodriguez Physical Therapy & Wellness may disclose your PHI, as necessary, to other healthcare providers involved in your treatment. Michelle Rodriguez Physical Therapy & Wellness may use and disclose your PHI to provide the treatment you require, such as communicate your PHI to a hospital or dispatch center and provide a hospital with information that we create while treating you.

Payment refers to activities Michelle Rodriguez Physical Therapy & Wellness undertakes to obtain reimbursement for your health care services. For example, Michelle Rodriguez Physical Therapy & Wellness may use and disclose your PHI to bill a third-party payer for the cost of treatment, equipment, and supplies provided to you.

Health Care Operations refers to the essential business functions necessary to operate as a healthcare provider. For example, Michelle Rodriguez Physical Therapy & Wellness may use or disclose, as needed, your PHI to support business activities, including quality assessment and improvement activities, employee review and evaluation activities, training, licensing, legal services, auditing, business planning, business management activities, and conducting or arranging other business activities.

Other Uses and Disclosures Allowed Without Authorization

New York State and Federal law allows us to use and disclose PHI without your written authorization in certain situations unless a more stringent state or federal law prohibits the use or disclosure. The examples of permitted uses and disclosures of your PHI include but are not limited to, those listed below.

Public Health Activities: Michelle Rodriguez Physical Therapy & Wellness may disclose your PHI for public health activities in certain situations and as required by law. For example, Michelle Rodriguez Physical Therapy & Wellness may use or disclose your PHI to public health authorities for public health activities such as preventing or controlling disease, injury or disability; a government authority authorized to receive child abuse or neglect reports; the **Food and Drug Administration** (FDA), for activities related to the quality, safety, or effectiveness of FDA-regulated products or activities, including drugs, food, medical devices, and dietary supplements; a person who may have been exposed to a communicable disease or who may be at risk of contracting or spreading a disease or condition; to a person or entity to prevent or lessen a serious threat to the health or safety of a person or the public; an employer, under certain circumstances, such as those related to work-related illness or injury; and a school, in certain circumstances, The **New York State Department of Health** is a public health authority that is authorized by law to collect, receive and disclose PHI for specific public health purposes include preventing or controlling disease, injury, or disability.

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Notice of Privacy Practices, Cont.

Health Oversight Activities: Michelle Rodriguez Physical Therapy & Wellness may disclose your health information to agencies authorized to perform health oversight activities. These activities may include audits, investigations, inspections, and licensure. They are necessary to monitor the operation of the health care system, government benefit programs such as Medicaid and Medicare, and compliance with Civil rights laws.

Lawsuits, Disputes, and Other Legal Matters: Michelle Rodriguez Physical Therapy & Wellness may disclose your PHI in response to a court or administrative order if you are involved in a lawsuit or administrative proceeding or as required by law. Sometimes, Michelle Rodriguez Physical Therapy & Wellness may disclose your PHI in response to a discovery request, subpoena, or other lawful process.

Law Enforcement: Michelle Rodriguez Physical Therapy & Wellness may disclose your health information to law enforcement officials to comply with a legal order or law we must follow. In certain circumstances, we are required to disclose your health information to law enforcement agencies.

Required by Law: Michelle Rodriguez Physical Therapy & Wellness will share information about you if required by state or federal laws.

Research: We can use or share your information for health research in limited circumstances, provided the researchers protect the information.

Workers' Compensation: Michelle Rodriguez Physical Therapy & Wellness may disclose your PHI as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs. Michelle Rodriguez Physical Therapy & Wellness ***WILL NOT*** use or share your information for any purposes not described in this **Notice of Privacy Practices** without your written authorization. You may revoke (take back) your written authorization at any time, except if action has already been taken based on your
authorization.

Your Rights Regarding Your Protected Health Information

Michelle Rodriguez Physical Therapy & Wellness are required by law to maintain PHI's privacy, provide you with a Notice of our legal duties and privacy practices with respect to PHI, and notify you if we discover a breach of unsecured PHI. As a patient, you have rights concerning your PHI, including:

Right to Request Restrictions on Uses and Disclosures: You have the right to request that NYSDOH VS limit specific uses and disclosures of your PHI. Any such request must be made in writing to the contact listed in this **Notice of Privacy Practices**. The specific restriction requested and to whom that restriction would apply must be stated. NYSDOH VS is not required to agree to certain restrictions that you request.

Your Right to Request Confidential Communication

You have the right to request that NYSDOH VS communicate with you about your health care or medical matters through a reasonable alternative way or at an alternative location.

Right to Access Your PHI: You can see and obtain a copy of your personal health-related information held by NYSDOH VS.

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Notice of Privacy Practices, Cont.

Right to Amend PHI: Michelle Rodriguez Physical Therapy & Wellness can amend your personal health-related information if you believe it is wrong or missing information, and NYSDOH VS agrees. If NYSDOH VS disagrees, you may have a statement of your disagreement added to your personal health-related information.

Right to Receive an Accounting of Disclosures: You can obtain a listing of those persons or organizations who receive your personal health-related information from NYSDOH VS. The listing will not cover health-related information that was disclosed to you, information disclosed for treatment, payment, or healthcare operations, or information used to conduct NYSDOH versus routine operations.

To file a complaint (if you believe your privacy rights have been violated), you can contact the NYSDOH VS by emailing **DLAhouse@health.ny.gov**, or by writing to the following address: **NYSDOH Privacy Officer, Corning Tower, 24th Floor, Empire State Plaza, Albany, NY 12237**. You may also file a complaint with the **Office for Civil Rights, US Department of Health and Human Services**. You will not be penalized for filing a complaint or assisting in an investigation. NYSDOH VS is required to follow the terms in this Notice. NYSDOH VS has the right to change how your personal health-related information is used and disclosed. Any new Notice will be available at our vaccine sites and by writing to: **NYSDOH Privacy Officer, Corning Tower, 24th Floor, Empire State Plaza, Albany, NY 12237**. You have the right to a paper copy of our current Notice of Privacy Practices at any time.

ACKNOWLEDGMENT

I acknowledge that I have received your **Notice of Privacy Practices**. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the **Notice of Privacy Practices**. I understand that I may request that you restrict how my private information is used or disclosed in writing. I also understand you are not required to agree to my requested restrictions, but if you do agree, you are bound to abide by such restrictions.

_____
Patient First and Last Name (Print)

_____
Responsible Party Name (if different from Patient, Print)

_____
Relationship of Responsible Party to Patient (Print)

_____
Signature of Patient or Responsible Party