PROACTIVE PHYSICAL THERAPY & SPORTS REHABILITATION, PLLC
465 COLUMBUS AVENUE, VALHALLA, NY 10595
TEL: (914) 741-2850 FAX: (914) 741-2851
(PLEASE COMPLETE ALL INFORMATION BELOW. PRINT NEATLY. THANK YOU.)

TODAY'S DATE:_____

Patient's First name:_____**Last name:**_____

Street Address_____

City, State, Zip_____

Home Phone _____**Work/Cell Phone**_____

DOB_____/_____/_____ **E-Mail**_____

Medicare patients: are you currently participating in home health care? [Yes] [No]

Who may we thank for referring you? _____

Referring Physician / Dr. who wrote the script: _____

IN CASE OF AN EMERGENCY: Contact: _____**relationship**_____

Telephone Number: _____

Patient's Allergies:_____

Primary Care Physician: _____ **Telephone:** _____

I authorize the release of any medical information to my Insurance Carrier to process this claim.
I permit a copy of this authorization to be used in place of the original.
I hereby authorize the physician(s) to apply for benefits on my behalf for services rendered.
I request that payment be made directly to ProActive Physical Therapy&Sports Rehabilitation,PLLC or its designee.
I certify that the information I have reported with regard to my insurance coverage is correct and accurate.
I understand that I am financially responsible for the charges incurred for services and supplies received.
I authorize the physician(s) to treat me and/or my child.

Signature
(Patient/Guardian):_____Date:_____

PROACTIVE PHYSICAL THERAPY & SPORTS REHABILITATION, PLLC
FINANCIAL POLICY

PATIENT RESPONSIBILITIES

- All patients must have a current prescription at the time of service to receive treatment.
- Full co-payments are expected at the time of service.
- It is your responsibility to be knowledgeable about your coverage and limitations. You must obtain the appropriate referrals from your primary care/referring physician. You are responsible for knowing how many visits have been authorized and when to obtain updated referrals, as necessary. You are responsible for knowing how many visits are allowed per year per condition and how many have been used. Proactive Physical Therapy will help you to keep track of visits made to this facility.

PRIMARY INSURANCE

- We will be happy to bill your insurance for you if you provide us with t he appropriate billing information. Your insurance will make payment directly to Proactive Physical Therapy and Sports Rehabilitation, PLLC. You will be responsible for any deductible, co-payments, or other patient balances. We will expect payment from you directly with certain policies and will submit the claims to the appropriate address. All bills are due and payable upon receipt of your monthly statement. Late payment charges will be automatically added to unpaid balances outstanding after 60 days.

PAYMENT OPTIONS

- Payment options include cash or check only.

CANCELLATION POLICY

- It is the policy of this practice to charge a patient **$45.00** for missed appointments or cancellation without proper notice. **Cancellation must be made by 7:30 p.m. the evening before to avoid this charge.** Payment of these charges will be required at the time of your next appointment. These charges are not billable to your insurance provider.

I have read and understand this financial agreement. I have had an opportunity to ask questions, and accept the responsibility of its terms.

_____ _____

Patient/Responsible Party's Signature Date

proACTIVE
PHYSICAL THERAPY &
SPORTS REHABILITATION, PLLC

465 Columbus Ave., Valhalla, NY 10595 (914) 741-2850 Fax: (914) 741-2851

ASSIGNMENT OF BENEFITS

I hereby authorize payment of medical benefits directly to ProActive Physical Therapy and Sports Rehabilitation, PLLC for services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by my insurance.

RELEASE OF INFORMATION

I authorize the release of medical records pertinent to my treatment at ProActive Physical Therapy and Sports Rehabilitation, PLLC to any insurance company, adjuster or attorney.

MEDICARE AUTHORIZATION

I certify that the information given to me in applying for payment under title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration, its intermediaries, or carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

**I agree that a copy or facsimile of this authorization form can be used in place of the original. This assignment will remain in effect until revoked by me.

_____ _____

Patient/Responsible Party Signature Date

_____

Print Name

PROACTIVE PHYSICAL THERAPY & SPORTS REHABILITATION, PLLC
HIPAA PRIVACY STATEMENT

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

NOTICE OF PRIVACY PRACTICES

OUR COMMITMENT TO YOUR PRIVACY: We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at our office or otherwise brought to our attention. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the office personnel.

USES AND DISCLOSURES

TREATMENT: Your health information may be used by staff members or disclosed to other health professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

PAYMENT: Your health information may be used to seek payment from your health plan and from other sources such as an automobile insurer that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided and the medical condition being treated. Lastly, if necessary, information may be used for an outside collection agency to collect any balance due to this facility.

HEALTH CARE OPERATIONS: Your health information may be used as necessary to support the day-to-day activities and management of ***Proactive Physical Therapy & Sports Rehabilitation, PLLC***. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

LAW ENFORCEMENT: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

APPOINTMENT REMINDERS: Our practice may use and disclose your personal health information to contact you to remind you of a scheduled or missed appointment.

OTHER USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION: Disclosure of your health information, or its use for any purpose other than those listed above, requires your specific written authorization. If you change your mind after authorizing a use or disclosure you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

ADDITIONAL USES OF INFORMATION: Appointment reminders: your health information may be used by our staff to confirm your appointments with this facility.

INFORMATION ABOUT TREATMENTS: Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

INDIVIDUAL RIGHTS: You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

DUTIES OF *PROACTIVE PHYSICAL THERAPY & SPORTS REHABILITATION, PLLC*: We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies that are outlined in this notice.

RIGHT TO REVISE PRIVACY PRACTICES: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

REQUEST TO INSPECT PROTECTED HEALTH INFORMATION: You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. Requests may be mailed to: ***Proactive Physical Therapy & Sports Rehabilitation, PLLC*, 465 Columbus Avenue, Valhalla, NY 10595.** Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

COMPLAINTS: If you would like to submit a complaint about our privacy practices, you can do so by sending a letter outlining your concerns to the aforementioned address or to the Secretary of Health and Human Services. If you believe that your privacy rights have been violated, you can call the matter to our attention by sending a letter describing the cause of your concerns to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

EFFECTIVE DATE: This notice is effective on or after February 25, 2015.

Print Patient's Name **Signature of Patient or Legal Guardian** **Date**

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name _____ **Date** _____

1. Describe your symptoms _____

_____

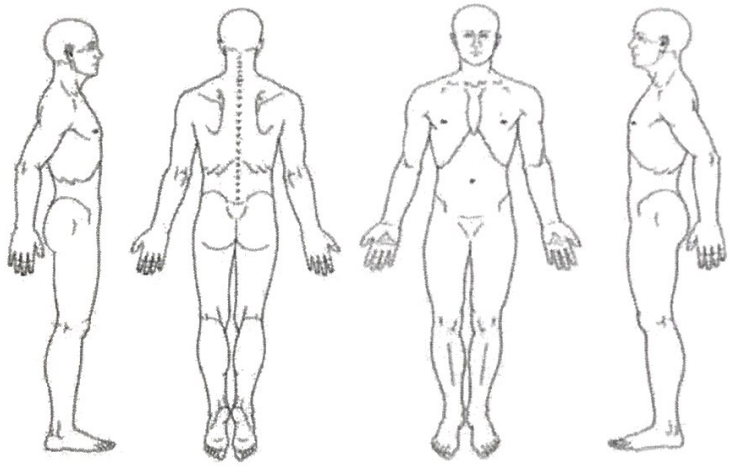
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

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8. Who have you seen for your symptoms?

① No One
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

10. What is your occupation?

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

_____

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

Patient Signature _____ **Date** _____

Patient Health Questionnaire - page 2

ACN Group, Inc PHQ-102

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight? Height [ ][ ][ ] Weight [ ][ ][ ] lbs.

Feet *Inches*

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present		Past	Present		Past	Present	
○	○	Headaches	○	○	High Blood Pressure	○	○	Diabetes
○	○	Neck Pain	○	○	Heart Attack	○	○	Excessive Thirst
○	○	Upper Back Pain	○	○	Chest Pains	○	○	Frequent Urination
○	○	Mid Back Pain	○	○	Stroke			
○	○	Low Back Pain	○	○	Angina	○	○	Smoking/Use Tobacco Products
						○	○	Drug/Alcohol Dependence
○	○	Shoulder Pain	○	○	Kidney Stones			
○	○	Elbow/Upper Arm Pain	○	○	Kidney Disorders	○	○	Allergies
○	○	Wrist Pain	○	○	Bladder Infection	○	○	Depression
○	○	Hand Pain	○	○	Painful Urination	○	○	Systemic Lupus
			○	○	Loss of Bladder Control	○	○	Epilepsy
○	○	Hip/Upper Leg Pain	○	○	Prostate Problems	○	○	Dermatitis/Eczema/Rash
○	○	Knee/Lower Leg Pain				○	○	HIV/AIDS
○	○	Ankle/Foot Pain	○	○	Abnormal Weight Gain/Loss			
			○	○	Loss of Appetite	***Females Only***		
○	○	Jaw Pain	○	○	Abdominal Pain	○	○	Birth Control Pills
			○	○	Ulcer	○	○	Hormonal Replacement
○	○	Joint Swelling/Stiffness	○	○	Hepatitis	○	○	Pregnancy
○	○	Arthritis	○	○	Liver/Gall Bladder Disorder	○	○	
○	○	Rheumatoid Arthritis						
			○	○	Cancer	***Other Health Problems/Issues***		
○	○	General Fatigue	○	○	Tumor	○	○	
○	○	Muscular Incoordination				○	○	
○	○	Visual Disturbances	○	○	Asthma	○	○	
○	○	Dizziness	○	○	Chronic Sinusitis			

Indicate if an immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○ _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

Patient Signature _____ **Date** _____

Doctor's Additional Comments

_____

_____

_____

Doctors Signature _____ **Date** _____