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provided by Fishbein Physical Therapy

patient registration

PATIENT INFORMATION

First Name, Middle Initial:	Last Name:	Marital Status: ☐ M ☐ S ☐ D ☐ W
Street Address:	City/State:	Zip Code:
Home Phone:	Work Phone:	Cell Phone:
Social Security #:	Sex: ☐ M ☐ F	Date of Birth:
Email Address (for scheduling use only):	Referring Doctor or Primary Care Physician:	

SOURCE OF REFERRAL

Why did you choose to have your physical therapy at Kinected with Elliot Fishbein? *(Choose one):*

- ☐ My doctor specifically recommended Elliot Fishbein.
  MD name: _____
- ☐ I chose Elliot Fishbein from a list my doctor provided me.
- ☐ My case manager specifically recommended Elliot Fishbein.
  Case manager name: _____
- ☐ A family member or friend recommended Elliot Fishbein.
  Name: _____
- ☐ I am a client at Kinected.
- ☐ I am a previous patient of Elliot Fishbein's.
- ☐ Internet (please specify):
  - ☐ Google ad
  - ☐ Citysearch
  - ☐ Yelp
  - ☐ Other
- ☐ Elliot Fishbein was listed on my Insurance Website/Provider Directory.
  Insurance company name: _____
- ☐ Phone book/yellow pages
- ☐ Advertisement
  Name of publication: _____
- ☐ Kinected website
- ☐ Direct access (no prescription from a doctor)
- ☐ Other:_____

Stay in touch!

- ☐ Check this box to receive monthly emails on studio events, health tips, & more.

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authorization, assignment, & acknowledgements

Release of Information:
Fishbein Physical Therapy is authorized to release any medical information needed to process applications for financial coverage for services rendered during the visits of the patient named below.

This information may be released to third party payors and others assisting Fishbein Physical Therapy in obtaining payment including billing, coding and collection agents and to its attorneys and consultants or to any employer as necessary to secure payment.

I/we further authorize Fishbein Physical Therapy to release medical records/information to the patient's primary care or referring physician.

Insurance & Reimbursement:
I understand that Fishbein Physical Therapy is a self-pay practice and does not accept insurance at this time, nor does it process claims with my insurance carrier. If requested, Fishbein Physical Therapy will, however, provide me with an itemized statement that I may submit to my insurance company for reimbursement of the services it may cover.

Guarantee of Payment/Financial Responsibility:
I understand that I am fully responsible for the balance due, based upon Fishbein Physical Therapy's charges which I agree are fair and reasonable.

I/we understand that any balance, is my/our responsibility. I/we agree to pay the balance within 30 days of receipt of invoice or contact Kinected to arrange a payment plan. Failure to respond as outlined above will result in the account being turned over to a collection agency. All balances in excess of 90 days are subject to a monthly finance charge of 1.5%.

I/we understand that if I/we am/are unable to attend a scheduled appointment, I am required to call to cancel the appointment 24 hours prior to said appointment; otherwise a $50.00 fee will be incurred which is not reimbursable by insurance.

HIPAA Acknowledgement:
I/we hereby acknowledge that I/we have received a copy of the Notice of Privacy Practices as required by HIPAA.

Direct Access:
I/we understand that, in New York state, patients are able to be evaluated and treated by a licensed physical therapist without a physician's referral, called Direct Access. I/we understand that in order to provide Direct Access treatment, the Physical Therapist must have practiced PT on a full-time basis for at least 3 years and be 21 years old. I/we understand that some insurance plans may still require me to consult with a physician first, in order to be reimbursed for services. I/we understand that Direct Access treatment can be rendered by a Licensed physical therapist for **10 visits** or **30 days**, which ever comes first; after one of these requirements has been reached, a physician's referral is necessary to continue treatment.

> ***Special Notice to Patients Seeing Physical Therapist without a Physician's Prescription – "Direct Access":*** *In accordance with the Office of the Professions of New York State Education Department, we must advise you in writing that the treatment may not be covered by the patient's health care plan or insurer* ***without a referral*** *from a physician, dentist, podiatrist, or nurse practitioner, and, treatment may be a covered expense if rendered* ***with a referral****.*

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Personal Valuables:
Fishbein Physical Therapy and Kinected are not be liable for loss or damage to money, jewelry, documents, or articles of value while the patient is present on its premises.

Email Communication:
I understand that Fishbein Physical Therapy and Kinected cannot guarantee the security of email communication. E-mail sent over the Internet is not secure and should not be used to communicate confidential and/or health information directly to Fishbein Physical Therapy and Kinected. Fishbein Physical Therapy and Kinected shall not be liable for any breach of confidentiality resulting from such use of e-mail via the Internet. If I choose to communicate with Fisbein Physical Therapy and/or Kinected regarding confidential medical information, I choose to do so at my own discretion.

Patient Consent:
I, the undersigned, do hereby authorize Fishbein Physical Therapy to furnish me (or the patient-minor mentioned below) with medical and physical care and treatment that is considered necessary and proper in diagnosing and/or treating my (or the patient-minor's) physical condition.

I acknowledge that no guarantees or assurances have been given to me concerning the results or findings intended from the treatment or examination at Fishbein Physical Therapy. I confirm that I have read and fully understand the above, and have been given the opportunity to ask questions, and that all my questions have been answered fully and to my satisfaction. This consent with cover every visit made by me (or the patient-minor) as long as I (or patient-minor) remain an active patient of Fishbein Physical Therapy.

Consent:
By signing my name below, I verify that I have read and agree to the information contained in this packet and that the information I have provided is true and accurate.

_____ _____
Patient's Signature (*or responsible party if the patient is minor or unable to sign*) **Date**

_____ _____
Relationship to Patient **Date**

_____ _____
Witness **Date**

FOR FEMALE PATIENTS ONLY
I understand that in the course of my treatment I may have x-rays or other diagnostic procedures. I agree to inform the health care providers if I am or may be pregnant prior to administering any diagnostic tests.

_____ _____
Patient's Signature (*or responsible party if the patient is minor or unable to sign*) **Date**

_____ _____
Relationship to Patient **Date**

_____ _____
Witness **Date**

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informed consent

To participate in sessions or classes at Kinected, in addition to sessions with Fishbein Physical Therapy, please complete this form:

I have agreed to participate in a program of progressive physical exercise with a Teacher at Kinected. The exercise program includes cardiovascular conditioning, muscle strength, endurance and flexibility work. The conditioning program utilizes Pilates, Kane Core Integration, Body Mind Centering, Iyengar and other methods of conditioning, strengthening, and stretching recommended by the College of Sports Medicine and International Dance Exercise Association. The possible benefits of this exercise program include: improving cardiovascular fitness, muscle strength, endurance, flexibility, body posture and alignment.

I recognize that exercise carries some risk to the musculoskeletal system (sprains, strains) and the cardiorespiratory system (dizziness, discomfort in breathing, heart attack). The possibility of certain unusual changes during exercise does exist. They include such conditions as muscle soreness or stiffness, abnormal blood pressure, fainting, disorders of heart beat and instances of heart attack and death. I hereby acknowledge and accept these risks. To my knowledge, I do not have any limiting physical conditions or disability that would prelude an exercise program. I hereby certify that I know of no medical problem (except those noted below) that would increase my risk of illness and injury as a result of participation in a regular exercise program.

Medical problems (if any): _____

I waive, indemnify, exonerate, hold harmless Kinected staff or employee of Kinected and their assigns for any claims, demands and causes of action (including attorney's fees) arising out of or pertaining to any loss, damage, injury or death sustained, caused by any negligent act or act of omission or my participation in the Kinected program or breach of duty related to Kinected. This release applies whether or not any claim, demand, action or suite is based upon or alleged to be based on or in part, the negligent act or act of omission or similar conduct of those parties are hereby released and indemnified. I do hereby assume all risk and hazards in volunteering to participate in the Kinected program. I hereby acknowledge that I possess adequate medical and hospitalization insurance coverage in case of injury. I further acknowledge that I might have the right to choose what exercises I do or do not perform in addition to withdrawing from any exercise at any time.

I ACKNOWLEDGE THAT I HAVE CAREFULLY READ THIS CONSENT AND FULLY UNDERSTAND THAT IT IS A RELEASE OF ALL LIABILITY. IN ADDITION, I DO HEREBY WAIVE ANY RIGHT THAT I MAY HAVE TO BRING A LEGAL ACTION OR ASSERT A CLAIM FOR INJURY OR LOSS OF ANY KIND AGAINST ME FOR MY NEGLIGENCE OR ARISING OUT OF OR RELATING TO PARTICIPATION BY ME IN ANY OF THE ACTIVITIES, OR USE OF THE EQUIPMENT, FACILITIES OR SERVICES PROVIDED TO ME BY KINECTED.

SIGNATURE _____ **DATE** _____

A physician's examination should be obtained by all participants prior to involvement in the exercise program. If a participant chooses not to obtain a physician's permission, she/he must sign the following statement:

I have been informed of the need for a physicians approval or participation in a progressive exercise/fitness program. I fully understand the strenuous nature of the program.

I accept complete responsibility for my health and well being in the voluntary exercise/fitness program and related testing and understand that no responsibility is assumed by the directors, owners, or employees of Kinected.

SIGNATURE _____ **DATE** _____

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attendance & studio policy

Fishbein Physical Therapy and Kinected strive to provide each patient with the highest quality of care while attempting to accommodate your schedule to your convenience. Therefore, we provide reserved time slots for each patient with a specific therapist in order to minimize waiting times and assure continuity of your personal treatment. Your consistent attendance of the planned treatment regimen is paramount to your full recovery.

Cancellations, especially last minute ones, along with patient no-shows, decrease our ability to accommodate the scheduling needs of other patients. We must ask for your full cooperation with the following policy:

PT Appointments

- If you are unable to keep a scheduled appointment, we request that you notify us 24 hours in advance of your scheduled appointment time. If someone is not available to take your call, please leave a message on our answering system.
- All cancellations and no-shows will be documented in our medical records and appropriately reported to your Physician and Insurance/Third Party Payor.
- If you accumulate 2 cancellations or no-shows, your therapist may refer you back to your Physician before scheduling another appointment or may choose to discharge you from therapy and report this to your Physician.
- If you do not honor a scheduled appointment either by late cancellation or no show, then you will be charged a fee of $50, due upon your next scheduled visit.

Studio Appointments

- All private Pilates and GYROTONIC sessions are 55 minutes and that all appointments must be made with the front desk staff.
- 24-hour notice must be given when canceling scheduled appointments and group equipment classes; clients are responsible for 100% of the service if 24-hour notice is not given.
- All payments are due on the day of service. There will be a $10 late fee for one-on-one sessions and $5 late fee for group classes not paid for on the date of service.
- All packages will begin on the day of purchase. Unpaid sessions dated before the purchase date will not be applied to the package. All packages have a one year expiration date from the date of purchase.
- All sales are final. There are no refunds for paid services.

We believe that these policies are necessary for the benefits of all patients and clients, so that we can continue to provide high quality treatment and service to everyone. All Fishbein Physical Therapy and Kinected staff and patients appreciate your cooperation and adherence with this policy.

Thank you.

Patient Signature_____**Date** _____

**Policies are subject to change without notice.*

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medical history

This is your confidential medical record to be utilized solely by your physical therapist.

Name: _____ Date: _____

Leisure activities, including exercise routines: _____

Occupation, including activities that comprise your workday: _____

Age: _____ **Height:** _____ **Weight:** _____

Are you on a work restriction from your physician?	**Yes**	**No**
Do you smoke?	**Yes**	**No**
Do you have a pacemaker?	**Yes**	**No**
Are you latex sensitive?	**Yes**	**No**
FOR WOMEN: Are you currently pregnant or think you might be pregnant?	**Yes**	**No**

ALLERGIES: List any medication(s) you are allergic to: _____

Have you RECENTLY noted any of the following (check all that apply)?

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ☐ fatigue
- ☐ fever/chills/sweats
- ☐ nausea/vomiting
- ☐ weight loss/gain difficulty
- ☐ maintaining balance while walking
- ☐ falls
- ☐ numbness or tingling
- ☐ muscle weakness
- ☐ dizziness/lightheadedness
- ☐ heartburn/indigestion
- ☐ difficulty swallowing
- ☐ changes in bowel or bladder function
- ☐ constipation
- ☐ diarrhea
- ☐ shortness of breath
- ☐ fainting
- ☐ cough
- ☐ headaches

Has anyone in your immediate family (parents, brothers sisters) EVER been diagnosed with any of the

- ☐ cancer
- ☐ heart problems
- ☐ chest pain/angina
- ☐ high blood pressure
- ☐ circulation problems
- ☐ blood clots
- ☐ stroke
- ☐ anemia
- ☐ chemical dependency (i.e., alcoholism)
- ☐ depression
- ☐ lung problems
- ☐ tuberculosis
- ☐ asthma
- ☐ rheumatoid arthritis
- ☐ other arthritic condition
- ☐ bladder/urinary tract infection
- ☐ eye irritation/infection
- ☐ sexually transmitted disease/HIV
- ☐ thyroid problems
- ☐ diabetes
- ☐ osteoporosis
- ☐ multiple sclerosis
- ☐ epilepsy
- ☐ kidney problems
- ☐ ulcers
- ☐ liver problems
- ☐ hepatitis

following conditions (check all that apply)?

- ☐ cancer
- ☐ heart problems
- ☐ high blood pressure
- ☐ diabetes
- ☐ stroke
- ☐ depression
- ☐ tuberculosis
- ☐ thyroid problems
- ☐ blood clots

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medical history

During the past month have you been feeling down, depressed, or hopeless? Y E S N O
During the past month have you been bothered by having little interest or pleasure in doing things? Y E S N O
Is this something with which you would like help? YES YES, BUT NOT TODAY NO
Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

Have you ever taken steroid medications for a medical condition? Y E S N O
Have you ever taken blood thinning or anticoagulant medications for a medical condition? Y E S N O

Please list any surgeries or other conditions for which you have been hospitalized (including dates):

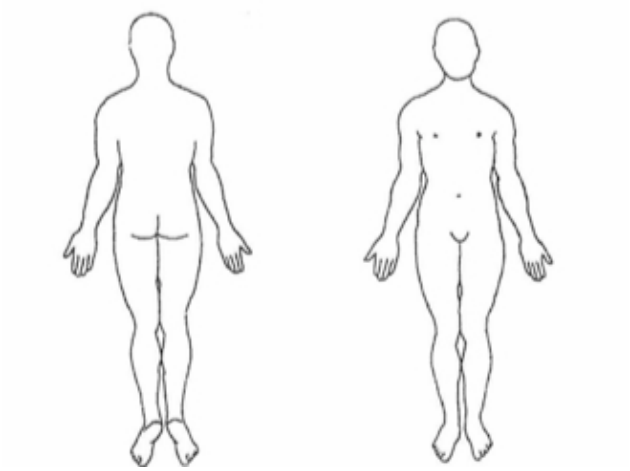
1. _____ 2. _____ 3. _____

What date (roughly) did your present symptoms start? _____
What do you think caused your symptoms? _____
My symptoms are currently: ☐ Getting better ☐ Getting worse ☐ Staying about the same
Treatment received so far **for this problem (chiropractic, injections, etc.):** _____
_____
Please list special tests performed for this problem (x-ray, MRI, labs, etc.): _____
_____
Have you ever had this problem before: YES NO When: _____
How long did it take for you to feel better? _____
Treatment received at that time: _____

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

↓ **Shooting/sharp pain**
O **Dull/aching pain**
||| **Numbness**
= **Tingling**



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medical history

My symptoms currently: ☐ Come & go ☐ Are constant ☐ Are constant, but change with activity

Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:

1. _____

2. _____

3. _____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

1. _____

2. _____

3. _____

How are you currently able to sleep at night due to your symptoms?

☐ No problem sleeping ☐ Difficulty falling asleep ☐ Awakened by pain ☐ Sleep only w/ medication

When are your symptoms **worst**? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After exercise

When are your symptoms the **best?** ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After exercise

Using the 0-10 pain scale, with 0 being ***"no pain"*** and 10 being the ***"worst pain imaginable"*** please describe:

Your current level of pain while completing this survey: _____

The best your pain has been during the past 24 hours: _____

The worst your pain has been during the past 24 hours: _____

Patient Signature_____ **Date** _____