IPA MANHATTAN
PHYSICAL THERAPY

Patient Information

Last name:____________________________first name:___________________________________mi: ______

home address: ____

city:__________________________________state:__________zip code: ___________________________________

mailing address: ____

city:__________________________________state:__________zip code: ___________________________________

home phone:__________________________business phone: ____

Cell phone:____

Date of birth:

Marital status: single // married // other sex: m // f

Email address:____

Desired primary form of contact (please circle one): email home # cell # work #

Emergency contact, legal guardian:__________________________phone number: ___________________

relationship to patient: ____

date of injury/surgery:_________________reason for visit: injury // accident // surgery who referred you to IPA Manhattan?____

Name of primary care physician:_____________________referring physician: ______________________

please describe injury briefly: ____

Insurance company: ____

group number:_________________________________policy/id: _______________________________________

policy holders name:__________________________policy holder's dob: ______________________________

policy holders address: ____

relationship to patient: ____

****It is the patient's or guardian's responsibility to inform IPA Manhattan of any changes to your insurance coverage or carrier*****

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past medical history

Please answer the questions below to the best of your ability prior to having your initial visit with your physical therapist.

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review of systems

Please mark the appropriate 'no' *lines, or provide details:*

---

no		details
______	general (*e.g. fever or chills, poor general health, unexplained weight loss, fatigue*)	______________________
______	skin (*e.g. rashes, new skin lesions, or a change in moles*)	______________________
______	eyes (*e.g. blurred vision, or change in visual acuity*)	______________________
______	ears (*e.g. ear pain, or difficulty hearing*)	______________________
______	nose (*e.g. nasal congestion, discharge, or bleeding*)	______________________
______	mouth/throat (*e.g. sore throat, or difficulty swallowing*)	______________________
______	respiratory (*e.g. shortness of breath, cough, wheezing*)	______________________
______	cardiovascular (*e.g. high/low blood pressure, palpitations*)	______________________
______	gastrointestinal (*e.g. nausea, vomiting, diarrhea, constipation, abdominal pain, discolored stools*)	______________________
______	genitourinary (*e.g. problems initiating or controlling my bladder, or problems with urinary frequency*)	______________________
______	endocrine (*e.g. heat or cold intolerance, weight loss or gain, increasing thirst*)	______________________
______	hemato-immunologic (*e.g. bruise easily, bleeding*)	______________________
______	psychiatric (*e.g. depression, anxiety, suicidal thoughts or attempts*)	______________________
______	smoking (eg. Occasional, daily, etc)	______________________

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please elaborate on any conditions from the previous page: ______________________

____

____

please list any other relevant medical history (*i.e. conditions or surgeries*) that your therapist should be aware of: ______________________

____

____

when did your pain start? ______________________

what do you think caused your pain? why? ______________________

what increases your pain? ______________________

since its initiation, has the pain changed? ______________________

have your symptoms: ( ) become worse ( ) become better ( ) remained the same?

What eases your symptoms?______________________

are you taking any medications? ( ) yes ( ) no

if yes, please list medications and dosage: ______________________

____

____

what are your goals of physical therapy? ______________________

____

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What to expect on 1st visit:

IPA MANHATTAN is made up of a group of dedicated and compassionate manual physical therapists whose goal is to improve the lives of our patient's using thorough evaluation and treatment techniques. The emphasis of care is Functional Manual Therapy, which includes Functional Mobilization, soft tissue and joint mobilization, back education, and individualized exercise programs.

Your initial evaluation will be completed in 1 hour and treatment may begin on the first visit if time permits. You should wear comfortable clothing that can easily expose the injured joint or body part. Our therapists can perform the physical therapy evaluation and treatment without a doctor's prescription. **Should you have any x-rays or medical documents for the therapist, please bring those along as well**. Being a new patient, it is important that you arrive a few minutes early so that we can process your paperwork and make a copy of your insurance card prior to your start time.

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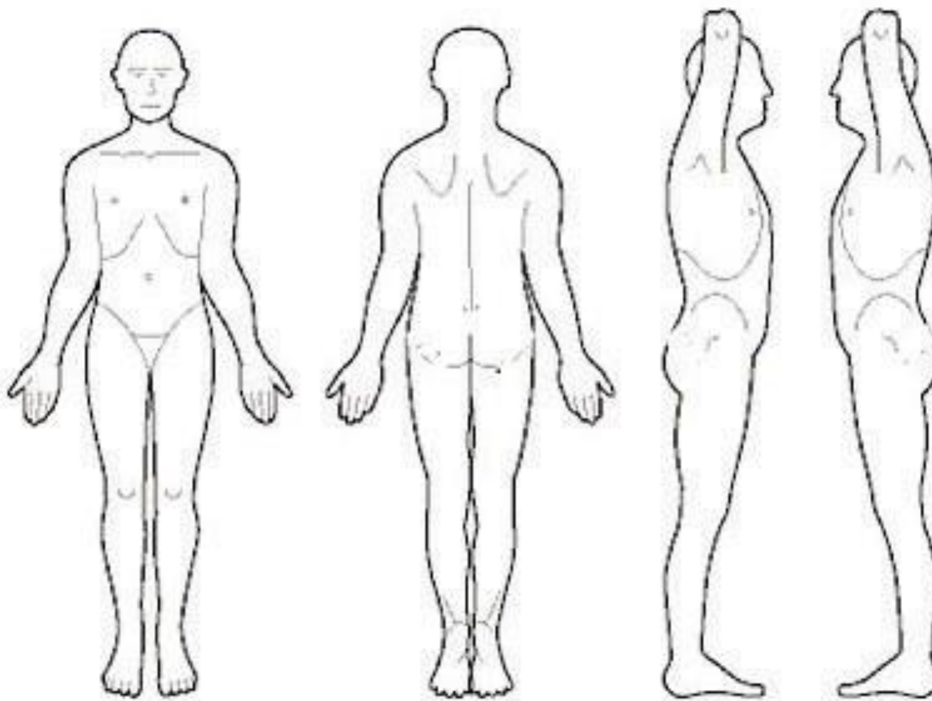
Draw on the figure below where you feel pain **TODAY**.

Use **X** *marks to show where you feel numbness, tingling or pins and needles* **TODAY**.

Use **O** *marks to show where you've had any symptoms prior to* **TODAY**.



***On the attached page you will be asked questions specific to your injury. Please answer the questions to the best of your ability as it will assist us in more accurately understanding your condition.*

On a scale of 0-10 (where "0" indicates "no pain" and "10" indicates "worst pain imaginable"), please rate the intensity of your pain:

Last 24 hours______________________ Since pain began__________________________

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physical therapy services

Mission statement:

IPA MANHATTAN's goal is to assist patients in their recovery from injury so they can return to a lifestyle that they can enjoy. We believe strongly in promoting overall wellness, and injury prevention. We design customized treatment programs to meet each patient's specific needs utilizing a Functional Manual Therapy Approach. Our Physical Therapists are committed to ongoing continuing education to ensure professional growth – All of our Therapists have obtained additional functional manual therapy certifications and advanced fellowship training that require years of consistent dedication to obtain. We believe in ongoing mentorship and continued clinical research as a means to continuously improve our patient outcomes. It is this combination of clinical expertise, genuine caring and a strong community reputation that sets IPA MANHATTAN apart.

Our therapists comply with privacy regulations set forth by HIPAA and will protect each patient's privacy without compromise.

IPA MANHATTAN is an out of network provider of physical therapy. As a courtesy, we will submit claims to your insurance company to assist with reimbursement of out of network benefits. IPA MANHATTAN cannot guarantee reimbursement. IPA MANHATTAN is not a Medicare provider. We cannot submit to Medicare for our patients.

Physical therapy fees:

Our initial evaluation fee is $350. Each subsequent treatment is $300/session.

IPA MANHATTAN will verify out of network physical therapy benefits. Should a problem be encountered, IPA MANHATTAN will assist by communicating with the patient's insurance company and by providing any clinical documentation required to process patient's physical therapy claims. We do not submit to or communicate with Medicare.

If a situation is presented where a patient will need at home treatment our fees are $525.00 for an initial evaluation and $500.00 for subsequent visits.

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payment and cancellation policy

payment & cancellation policy

Payment is expected at the time services are rendered, unless a credit card is kept on file. Patients will be billed bi-monthly via credit card on file, or following each therapy session if paying by cash or check.

Please be advised that IPA MANHATTAN is not a credit grantor, and therefore, failure to make timely payments may result in the placement of your account with a collection agency or attorney for collection.

IPA MANHATTAN ***has a 24 hour cancellation policy.***

All appointments cancelled less than 24 hours will be charged a cancellation fee.

My signature below indicates that I have read and understood IPA MANHATTAN payment and cancellation policy. I further indicate that I have received a copy of the HIPAA policy and procedures and it has been explained me. Additionally, my signature below authorizes IPA MANHATTAN to release my medical records and any relevant information to my insurance company for reimbursement. My signature also indicates my permission to be evaluated and treated by a licensed physical therapist from IPA MANHATTAN.

Signature of patient or guardian: X ______________________________

Please indicate your preferred method of payment below:

Please bill my credit card: visa // mastercard // american express

credit card number:______________________________exp date: ______________________________

My signature indicates permission for IPA MANHATTAN to bill my credit card: $350 for the initial evaluation and $300 per physical therapy session. These fees also apply to no show appointments and sessions cancelled < 24 hours as described above.

Signature of card holder: X ______________________________

I understand by electing not to keep a credit card on file with IPA MANHATTAN, *I will be responsible for payment following each therapy session.*

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hippa privacy and disclosure notice

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.

Federal Law (the Health Insurance Portability and Accountability Act (HIPAA)) requires that health care providers inform patients of their rights regarding how the provider may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This Privacy Notice describes our privacy practices that relate to your protected health information. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" means any written and oral health information about you, including demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition.

Your health record and protected health information:

Each time you receive medical care from our practice, a record of your visit is created. This record typically includes, but is not limited to, information such as your name, age, address, a brief medical history, symptoms, any test results, the treatment provided to you, treatment plans devised for your care, and notes on follow-up care to be performed. How your health care information may be used and what control you may exercise over the use of your healthcare information is described in this Privacy Notice.

Uses and disclosures of protected health information:

Our Practice may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless the practice has obtained your authorization or the use or disclosure is otherwise permitted by the HIPAA privacy regulations or state law. Disclosures of your protected health information for the purposes described in this Privacy Notice may be made in writing, orally, or by facsimile.

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and 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 protected health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies 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.

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Health Care Operation: your health information may be used as necessary to support the day-to-day activities and management of IPA SOHO. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality. Other examples might include: employee review activities, training programs including those in which students, trainees, or practitioners in health care learn under supervision, accreditation, certification, licensing or credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and maintaining compliance programs, and business management and general administrative activities. In certain situations, we may also disclose patient information to another provider or health plan for their health care operations.

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.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

other uses and disclosures for health care operations may include:

Appointment Reminders: Your health information may be used to contact you, a family member or friend involved in your health care as authorized by you as a reminder that you have an appointment for treatment or medical care at our facility. We may also leave a message on your answering machine / voicemail system unless you tell us not to.

Treatment Alternatives: We may use or disclose your protected health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health Related Benefits and Services: We may use or disclose your protected health information to tell you about health related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment of Your Care: We may disclose your protected health information to a friend or family member who is involved in your medical care. We may also give information to someone assisting you in the payment for your care. We may also tell your family or friends that you are in the facility at the time of your care. If you want any of this information restricted you must communicate that to us using the appropriate procedure.

Worker's Compensation: The facility may release your health information to comply with worker's compensation laws or similar programs.

You may object to these disclosures. If you do not object to these disclosures or we can infer from the circumstances that you do not object or we determine, in the exercise of our professional judgment, that it is in your best interests for us to make disclosure of information that is directly relevant to the person's involvement with your care, we may disclose your protected health information as described.

Uses and Disclosures which you authorize: Other than as stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon the authorization.

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Individual rights

Although your health record is the physical property of the healthcare practitioner or Facility that compiled it, the information belongs to you. 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 amend or submit corrections to 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*

Please contact our HIPAA Privacy Officer if you have questions about access to your medical record.

Ipa Manhattan duties

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 also are required to abide by the privacy policies and practices 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.

Requests 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. You may obtain a form to request access to your records by contacting Joseph Grant. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

We encourage you to express any concerns you may have regarding the privacy of your information. If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Brad Gilden, MS PT, DPT, CFMT, CSCS, Owner IPA Manhattan
18 E. 48th Street Suite 701 New York, NY 10017
(212)226-4816

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PATIENT CARE TEXT MESSAGING CONSENT FORM

DECLARATION

I, ____consent to IPA Manhattan Physical Therapy contacting me by text message for the purposes of appointment reminders. I acknowledge that appointment reminders by text are an additional service and that these may **NOT** take place on **ANY OTHER** occasions, and that the responsibility of attending appointments or cancelling them still rests with me.

I can cancel the text message facility at any time. This new service does not offer a reply facility to enable patients to respond to texts directly. I understand that they are transmitted over a public network onto a personal telephone and as such may not be secure. However, IPA Manhattan Physical Therapy will not transmit any information which would enable an individual patients' to be identified. I agree to advise IPA Manhattan Physical Therapy if my mobile number changes or if this is no longer in my possession.

Please print…………………………………………………………………
Signature……………………………………………………………………..
Mobile telephone#……………………………………………………..
Cell phone carrier……………………………………………………

The practice does not share mobile phone contact details with any external organization.

□ I DO NOT CONSENT TO THE PRACTICE CONTACTING ME BY TEXT MESSAGING

Signature____