HUDSON
PHYSICAL THERAPY

REGISTRATION FORM

PATIENT INFORMATION:

First Name: _____ MI: _____ Last Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Date of Birth: _____ Age: ___
Gender: ☐ Male / ☐ Female / ☐ Other _____
SS#: _____
Marital Status: ☐ Single / ☐ Married / ☐ Divorced / ☐ Other
Employer: _____ Occupation: _____
Work #: _____
Employer Address: _____

Preferred Contact:

☐ Home: _____ ☐ Cell Phone: _____
☐ Email: _____

Appt. Reminders: ☐ Text / ☐ Voice call / ☐ None
Emergency Contact #: _____
Name/ Relationship: _____/_____

Doctor Information:

Referring Physician: _____

Address: _____

Phone Number: _____ Fax Number: _____

Primary Physician: _____ Phone Number: _____

Have you received Physical Therapy or Occupational Therapy treatment within the last 12 months? ☐ Yes / ☐ No
Have you attended any Chiropractic, Speech Therapy or Home Care? ☐ Yes / ☐ No

Hudson Physical Therapy Clinic
2600 Netherland Ave, Suite 121
The Bronx, NY 10463

T: 929-800-2011
F: 844-502-8763
E: appointment@hudsonptot.com
W: www.hudsonptot.com

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INSURANCE INFORMATION:

Primary Insurance Company:

_____

Member ID#: _____ Group ID# : _____
Is this the Patient's insurance? ☐Yes / ☐No
If No who is the policy holder: _____
Policy Holder DOB: _____Relationship to patient: _____

Secondary Insurance Company:

_____

Member ID#: _____ Group ID#: _____
Is this the Patient's insurance? ☐Yes / ☐No
If No who is the policy holder: _____
Policy Holder DOB: _____Relationship to patient: _____

*** If you have a tertiary insurance please notify our office immediately. ***

Accident Information: Auto (NF) or Workers Compensation (WC)

Is this work related? ☐ Yes / ☐ No - Auto Accident? ☐ Yes / ☐ No
Date of Accident/Injury: _____
Surgery: ☐ Yes / ☐ No
Date of surgery: _____
What State did the accident occur in: _____
Attorney Information: Name/Firm-
_____
Attorney address: _____
Phone: _____
NF/WC Insurance Carrier: _____
Claim Number: _____ Policy Number: _____
Adjuster Name: _____ Phone Number: _____
Adjuster Email: _____ Fax Number: _____

Is your claim open? ☐ Yes / ☐ No
Is your adjuster aware you are starting therapy? ☐ Yes / ☐ No

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MEDICAL HISTORY:

Height: _____Weight: _____

Please tell us where you have pain or other symptoms:

_____

_____

- o Congenital Heart Defect
- o Heart Problems/ Heart Disease
- o Joint, Tendon or Muscular Pain
- o Osteoporosis
- o Pacemaker
- o High or Low Blood Pressure
- o Chest Pain/ Angina / Palpitations
- o Abdominal Pain/ Bloating/ Gas
- o Shortness of Breath
- o Coughing/ Wheezing or Exertion
- o Gout
- o Rheumatoid Arthritis
- o Anemia
- o Circulation / Blood Clots
- o Liver Disease
- o Sexually Transmitted Disease/ HIV/ AIDS
- o Lung Disease
- o Allergies
- o Asthma/ Bronchitis/ Pneumonia
- o Chemical Dependency (Alcoholism)
- o Lyme Disease
- o Painful Bowels/ Loose Stool/ Constipation
- o Depression/ Anxiety / Panic Attacks
- o Cancer
- o Joint Replacement/ Repair
- o Gastrointestinal Issues
- o Skin Problems
- o Psychological
- o High or Low Blood Sugar
- o High Cholesterol
- o Emphysema
- o Poor Balance Recent Falls
- o Dizziness/ Vertigo/ Fainting
- o Severe Headaches
- o Prostate Problems
- o Epilepsy/ Seizure Disorders
- o Ulcers
- o Kidney Disease
- o Tuberculosis
- o Thyroid Problems
- o Diabetes
- o Stroke
- o Latex Allergy
- o Hepatitis A, B, C
- o Multiple Sclerosis
- o Other: _____

Please provide details regarding the above checked conditions:

_____

_____

Medications: *Please list all over the counter and prescription medications you are currently taking. Include dosage & frequency*

_____

_____

_____

Surgical History: *List any surgical procedures you have had and the dates they were performed.*

_____

_____

Diagnostic Testing: *Please check any diagnostic testing and/or treatments you have completed for this condition:*

o MRI	o CT Scan	o X Ray	o Bone Scan
o EMG	o Cardiac Stress Test	o Nerve Block	o Ultrasound
o Blood Tests	o Doppler Studies	o Injections	o Urinalysis

Other: _____

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FINANCIAL RESPONSIBILITY INFORMATION

Integrative Manual Physical Therapy P.C., DBA Hudson Physical Therapy, has the focus of your overall health and wellness. As we help you meet these standards, it is important to us that you understand the terms "Medically Necessary", "Clinically Appropriate", "Benefit Maximum Met" and how this relates to your treatment.

"**Medically necessary**" refers to treatment or services that are specific to your diagnosis. When treatment is deemed medically necessary, your insurance company will reimburse Integrative Manual Physical Therapy P.C. DBA Hudson Physical Therapy for services performed according to physical therapy care, and has a direct connection to document improved function based on our contractual agreement.

"**Clinically Appropriate**" or "**Benefit Maximum**": Insurance companies may deny care despite treatment that continues to manage, reduce or eliminate your pain. This may be "clinically appropriate" for your circumstances but may not be considered "medically necessary" by your insurance carrier. Benefit Maximum is defined as a specific number of physical therapy visits allowed by your insurance policy during a specific time frame. Most treatments reach a point where no further improvement can be expected. This is called the point of maximum therapeutic benefit (MTB). MTB can be reached when complaints either fully resolve, or when pain and/or disability persist – even with ongoing treatment.

"**Denials/Appeals**": It is a patient's responsibility to initiate an appeal with the insurance provider when services are denied. Integrative Manual Physical Therapy P.C. DBA Hudson Physical Therapy will provide the necessary clinical information upon request. If your insurance company determines that services are no longer medically necessary, you will be billed $75.00 per visit for services that have been rendered.

In certain cases, your insurance company may send the reimbursement for services provided directly to you, the patient, via checks. In such cases the patient is obligated to bring all said checks and reimbursements to Integrative Manual Physical Therapy P.C. DBA Hudson Physical Therapy with all forms attached as given by their insurance company.

I understand it is my responsibility to confirm my coverage with my insurance carrier and that Integrative Manual Physical Therapy P.C. DBA Hudson Physical Therapy may verify such coverage as a courtesy to me. Integrative Manual Physical Therapy P.C. DBA Hudson Physical Therapy will not be held responsible or liable for inaccurate information or denials provided by your insurance carrier after services have been rendered.

My signature below acknowledges that I have read and fully understand that:

1. Integrative Manual Physical Therapy P.C. DBA Hudson Physical Therapy has discussed medical necessity limitations, clinically appropriate care, and the specific number of office visits allowed per my insurance company.
2. I have been informed of my financial responsibility if my insurance company denies all or part of these services as not medically necessary.
3. I fully accept the financial responsibility to pay for denied services at the time my insurance carrier deems my treatment not medically necessary.
4. I am ultimately responsible for all payment obligations arising out of my treatment or care and guarantee payment for these services. I am responsible for any deductibles, co-payments, co-insurance amounts or any other patient responsibility indicated by my insurance carrier.
5. I agree that in case of my insurance company directly reimbursing me for physical therapy services provided, I am obligated to bring all given reimbursements to Integrative Manual Physical Therapy P.C. DBA Hudson Physical Therapy.

Date: _____

Patient Name: _____

Patient Signature: _____

Parental Signature for Minor: _____

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CONSENTS AND DISCLOSURES

(I) CONSENT TO RELEASE INFORMATION TO FAMILY OR FRIENDS

Ordinarily, discussion of medical records or billing information would not be disclosed to anyone but yourself over the phone. However, with your consent, our staff will speak with your significant other, close family member or other designated individual. Please understand that you are waiving your right to confidentiality if this consent is given.

_____ **INITIAL HERE TO GIVE CONSENT:** I am hereby giving my consent to Hudson Physical Therapy office staff to discuss my medical condition or billing concerns with the person/persons I have designated below.

Name: _____ Relationship: _____

_____ **INITIAL HERE TO DECLINE CONSENT**

(II) CONSENT TO RELEASE INFORMATION TO A TELEPHONE ANSWERING MACHINE

In an effort to protect your confidentiality, medical history and appointment reminder specifics (including date & time) will not be left on your answering machine, email and/or received in a text message; however, if you prefer us to do this, we can with your consent. Please understand that you are waiving your right of confidentiality if you give your permission.

_____ **INITIAL HERE TO GIVE CONSENT**: I am hereby giving my consent for the Hudson Therapy office staff to leave medical history or appointment reminders (including date & time) on my telephone answering machine, email and/or text message.

_____ **INITIAL HERE TO DECLINE CONSENT**

(III) PATIENT AUTHORIZATION TO TREAT AND SUBMIT MEDICAL CLAIMS

I authorize payment to Hudson Physical Therapy for all physical therapy services rendered. I also understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered.

I consent to be assessed by and to receive treatment from Hudson Physical Therapy consistent with a plan of care. I confirm that I have been informed and have participated in planning the care and procedure(s) to be carried out by Hudson Physical Therapy and sign this consent willingly and voluntarily.

I consent to the release of information and/ or disclosure to Hudson Physical Therapy of all or any part of my medical record to other health care providers involved in my care or third-party payers as is necessary for processing claims.

I am aware my child is receiving Physical/Occupational Therapy at Hudson Physical Therapy. I am unable to attend his/her office visits. Please accept this form as my consent to treat my child.

Parent/ Guardian initials if applicable: _____

I have read and fully understand the above Consents and Disclosures.

Patient Signature: _____Date: _____

Parental Signature for Minor: _____Date: _____

NO SHOW/CANCELLATION POLICY

As a courtesy to other patients, as well as the Hudson Physical Therapy staff, we would appreciate a call of notification to cancel appointments at least 24 hours prior to your scheduled appointment. Please make sure to reschedule your appointment after cancelling. If a no call is received/documented your visit will be counted as a "NO SHOW." In reference to missing or not showing to your scheduled appointment without prior notification, a fee of $40 will be collected upon your next visit. Hopefully, this policy will ensure better scheduling availability as to not block appointments for other patients. Should there be any misunderstandings or miscommunications regarding your scheduled appointment, please speak to our office manager.

Referrals

PLEASE CHECK IF YOUR INSURANCE CARRIER REQUIRES A REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN. **REFERRALS ARE PATIENT RESPONSIBILITY AND MUST BE COMPLETED AND TURNED IN TO HUDSON PHYSICAL THERAPY ON TIME TO AVOID ANY INSURANCE DENIALS**.

Verification of Benefits

Hudson Physical Therapy verifies patient benefits with your insurance carrier as a courtesy to the patient. Benefits quoted are not a guarantee of payment. Patient is ultimately responsible for any denied services rendered at Hudson Physical Therapy.

We thank you in advance for your cooperation

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PATIENT BILL OF RIGHTS

Hudson Physical Therapy strives to ensure that each patient is provided the highest quality of care in accordance with the high professional standards that we continually maintain and review. We understand that patients have entrusted their care to us and we treat all patients with dignity, respect, and only provide appropriate services as needed. By requiring informed consent for treatment, we assure that each patient and/or his/her representative is involved in aspects of a treatment plan. Patients and their representatives are afforded consideration of their privacy concerning their own medical care program. Case discussion, consultation, examination and treatment are considered confidential and should be conducted discreetly. The patient has the right to full information in layman's terms concerning diagnosis, treatment and prognosis, including information about alternative treatments and possible complications. We will endeavor to involve patients in their treatment program by taking into account their feelings, interests, attitudes and goals in both the treatment planning and implementation process. A patient has the right to physical therapy services without discrimination based upon race, color, religion, sex, sexual preference or national origin.

I have read and fully understand the above Patient Bill of Rights.

Patient Signature: _____ **Date:** _____

Parental Signature for Minor: _____ **Date:** _____