Michael S. Brown P.T., P.C.
Dba/ Island Rehabilitation Associates

APPT DATE & TIME
_____
THERAPIST_____

Therapist Preference: Male/Female

DATE: _____

NAME: _____ DOB _____
SEX: M F

ADDRESS:
_____

PHONE: (____) _____ ALT PHONE: (____) _____

GENERAL INFORMATION

SOCIAL SECURITY NUMBER: (PATIENT) _____ MARITAL STATUS: M S D

REFERRING DOCTOR: _____ PHONE #: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ID# _____

NAME OF THE INSURED: _____ DOB _____

COPAY: $ _____

SECONDARY INSURANCE: _____ ID# _____

NAME OF THE INSURED: _____DOB _____

COPAY: $ _____

DIAGNOSIS

PRIMARY COMPLAINT: _____ DIAGNOSIS: _____

PATIENT/AUTHORIZED REPRESENTATIVE SIGNATURE:

_____ DATE: _____

Emergency Contact Information Form

This information will be extremely important in the event of an accident or medical emergency.

Please be sure to sign and date this form

Name: _____
Last First MI

Phone:
Home: _____ **Cell:** _____

Home Email Address: _____

Address: _____
Street City State Zip Code

Primary Emergency Contact Name: _____
Last First

Relationship: _____

Phone:
Home: _____ **Cell:** _____ **Work:** _____

Secondary Emergency Contact Name: _____
Last First

Relationship: _____

Phone:
Home: _____ **Cell:** _____ **Work:** _____

Preferred Local Hospital: _____

Insurance Information:

Company: _____ **Policy #:** _____

Comments *(include any special medical or personal information you would want an emergency care provider to know – or special contact information:*

Signature: _____ **Date:** _____

Physical Therapy Initial Evaluation Form

PATIENT INFORMATION Date: _____

Name: _____ DOB: _____ Age: _____yrs

Height: _____ Weight :_____lbs

Home Phone: _____ Cell #: _____

Currently Employed? □ Yes □ No Occupation: _____

Employer: _____

REHAB INFORMATION

1. Chief Complaint/ Ailment / Injury: _____
2. Date of Injury: _____ Date of Surgery: _____
3. Briefly describe how you were injured:
   _____
   _____
   _____
4. Have you received any therapy for this condition? □ Yes □ No If yes, when? _____
   How many visits? _____
5. Has your condition been getting □ Worse □ Same □ Better?
6. Are your symptoms □ Constant or □ Intermittent?
7. Mark the number that best corresponds to your pain:
   At Best: □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 (Excruciating Pain)
   At Worst: □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 (Excruciating Pain)

8. Does your pain decrease / condition improve with any of the below? (check all that apply)

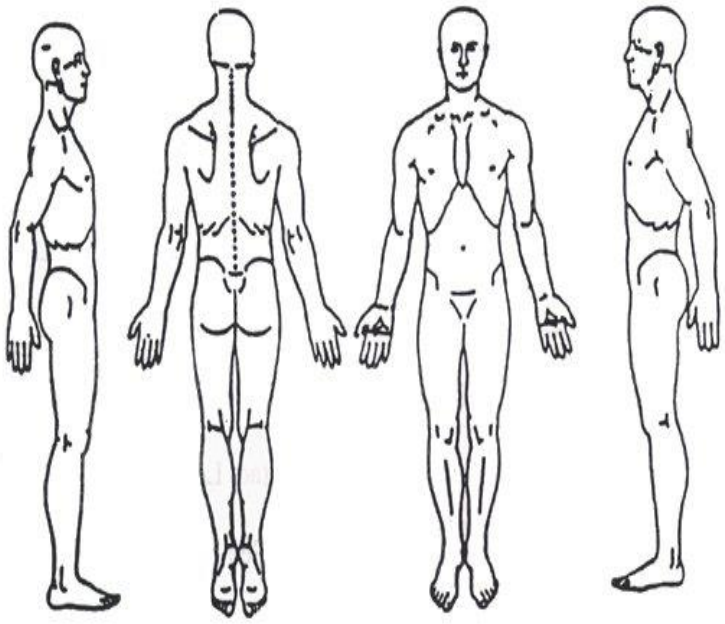
□ Bending	□ Movement	□ Rest	□ Better in AM
□ Sitting	□ Standing	□ Heat	□ Better as Day Progresses
□ Rising	□ Walking	□ Ice	□ Better in PM
□ Changing Positions	□ Lying	□ Medication	□ N/A (cast just removed)

9. Does your pain increase / condition worsen with any of the below? (Check all that apply)

□ Bending	□ Movement	□ Rest	□ Sneezing
□ Sitting	□ Standing	□ Stairs	□ Deep Breath
□ Rising	□ Walking	□ Coughing	□ Medication
□ Prolonged Positioning	□ Lying	□ Worse in AM	□ Worse in PM
□ Worse as Day Progresses	□ N/A (cast just removed)		

10. Previous Medical Intervention (check all that apply)
    □ X-ray □ MRI □ CT Scan □ Injections □ Other _____

DRAW IN AREAS OF PAIN ON BODY DIAGRAM USING THE CORRESPONDING NUMBERS:



Severe Pain - 1

Moderate Pain - 2

Dull Ache - 3

Radiating Pain - 4

Numbness / Tingling - 5

Medical Information (check all that apply) **This information is confidential and remains in your chart**

□ Difficulty Swallowing	□ Motion Sickness	□ Stroke	□ Pregnancy
□ Arthritis	□ Fever/ Chills/ Sweats	□ Osteoporosis	□ Diabetes
□ High Blood Pressure	□ Unexplained Weight Loss	□ Anemia	□ Fibromyalgia
□ Pacemaker	□ Shortness of Breath	□ HIV/ Hepatitis	□ Cancer
□ Epilepsy/ Seizures	□ History of Smoking	□ History of Alcohol Abuse	
□ History of Drug Abuse	□ Myofascial Pain	□ Depression / Anxiety	

Previous Surgeries:

_____

_____

Other: _____

Medications:

_____

_____

_____

Allergies:

_____

ISLAND REHABILITATION ASSOCIATES

Patient Information Sheet

Patient Name: _____ Date:_____
Age: _____ Sex:_____ Occupation:_____ Marital Status: _____
Referring MD: _____
Primary Care Physician: _____

What are your current complaints/symptoms: _____

Have you been treated for this condition before? (if yes, please specify)_____

Are you taking any medications for this condition or any other? Y / N (if yes, please list)_____

Have you had any diagnostic tests performed for this condition? (Please circle Y or N)
X-RAY: Y / N Date: _____ Results: _____
EMG: Y / N Date: _____ Results: _____
MRI: Y /N Date: _____ Results: _____

Do you have any other medical conditions? (If YES, please check or list)
Cardiac _____ Diabetes _____ Asthma _____ Hypertension _____ Cancer _____
Other _____

Have you ever been treated in physical therapy before? Y? N ?
If yes, please specify area treated _____

Have you had any prior surgeries? (If yes, please list) _____

Do you have a Pacemaker or Defibrillator Implant? Y / N

Are you pregnant? Y / N
Social History: (Please circle Y or N)
Drug Use? Y / N Alcohol Use? Y / N
Smoke? Y / N, # packs per day ____ Have you quit? Y / N, # of years ago _____

I understand that the above information is very important to any health care professionals rendering their services to me. I, therefore state I have answered the above questions truly and accurately to the best of my knowledge.

Signature: _____ **Date:** _____

Michael S. Brown, P.T, P.C
Dba Island Rehabilitation Associates
300 Hempstead Turnpike, West Hempstead, NY
Phone: 516- 505- 2200 Fax: 516- 505-5416

Notice of Patient Responsibility

You are responsible for all the fees associated with your care, this includes:

1. Co pays
2. If you should require Electrical Stimulation as a part of your treatment there will be a one-time fee of $10.00 for the electrodes as this is non-reimbursable by your insurance company.
3. It is YOUR responsibility to understand YOUR benefits and all the obligations set forth by your insurance company!

Payment is expected at the time of service unless arrangements have been made in advance.

There is a **$10 billing fee** for payments not made at time of visit.

For Weekends only – There is a **$50 no show fee** for all appointments that are not cancelled 24 hours in advance.

By signing below, I acknowledge that I have read and understand the above information

Patient Name _____

OPTIONAL

I authorize any outstanding payments for services (including co pays, late fees, deductibles, etc) to be automatically billed to my credit card. I understand that I will not be billed the administrative billing charge if my account it kept current. This authorization will be kept on file. I will provide the office with written notification in the event that I want to change any information on file.

Signature_____
Account Type: MasterCard Visa
Account Number: _____
Expiration Date: _____ Security Code: _____

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I, the undersigned, understand that my signature requests and represents that payments be made, and authorizes release of medical information to third party payors or insurance companies necessary to pay and all claims generated by medical services provided by Island Rehabilitation Associates.

I understand that Island Rehabilitation Associates, in insurance assigned cases, agrees to accept the determination of the insurance company as the full charge, and that **I AM RESPONSIBLE ONLY FOR THE DEDUCTIBLE, CO-INSURANCE AND NON-COVERED SERVICES PROVIDED.**
Co-insurances and deductibles are based upon the determination of the insurance company.

I further understand that, in case of denial of a claim by a third-party payor, or as a result of a dispute with such payor, I will remain fully responsible for the charges, with no time limitation from the date of service to the date of billing.

PATIENT SIGNATURE:
DATE: _____

Acknowledgement of Receipt of Notice of Privacy Practices

Island Rehabilitation Associates reserves the right to modify the privacy practices outlined in the notice. Signature

I have received a copy of the Notice of Privacy Practices for Island Rehabilitation Associates.
Name of Patient (Print or Type)

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

_____
Relationship of Patient Representative to Patient

Notice of Privacy Practices

Uses and Disclosures

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 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.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of **Island Rehabilitation Associates**. 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.

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 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 of your information 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.

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

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 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

Provider 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 ou office at (516) 505-2200. 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 comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Island Rehabilitaion Associates
300 Hempstead Turnpike, Suite 3
West Hempstead, NY 11552

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.