PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name_____Date: _____
Address_____ Apt #_____ City _____ Zip_____
Home Phone # (_____)_____ Social Security # _____
Gender: □ Female □ Male Date of Birth_____Age _____
Martial Status: □ Married □ Single □ Divorced □ Widowed □ Separated
Employer _____ Work Phone # (_____)_____
Work Address _____ City / State / Zip _____
Occupation _____

EMERGENCY CONTACT

Name _____ Relationship to Patient _____
Phone # (_____)_____ Address _____

INSURANCE INFORMATION

PRIMARY INSURANCE_____ Insured ID # _____
Name of Insured _____ Insured Date of Birth _____
Relationship to Insured: □ Self □ Spouse □ Child Phone # (_____) _____
Address _____ City / State / Zip _____

SECONDARY INSURANCE_____ Insured ID # _____
Name of Insured _____ Insured Date of Birth _____
Relationship to Insured: □ Self □ Spouse □ Child Phone # (_____) _____
Address _____ City / State / Zip _____

Was illness / injury connected with patient's employment? □ Yes □ No
Was illness / injury the result of an accident? □ Yes □ No
If yes, please explain_____
Referring Physician _____ Date of Script _____ Phone# (____)_____

AUTHORIZATION TO RELEASE INFORMATION
ASSIGNMENT OF BENEFITS / AGREEMENT / CONTRACT

I hereby authorize Optimal Rehabilitation OT & PT, PLLC.to release of any information pertinent to my case to Health Care Financing Administration or any carrier, adjuster, or attorney involved in this case.

I hereby instruct and direct my insurance company to pay by check made out and mailed to Dynamic Rehab PT, PC. If my current policy prohibits direct payment to provider, I hereby also instruct and direct my company to make out the check to me and mail it as follows: **Dynamic Rehab PT, PC 55 Meadowlands Pkwy, Secaucus, NJ 07094** for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY**. This payment will not exceed my indebtedness to the above-mentioned assignee. **I hereby agreed to full responsibilities for all expenses and to pay any balance of said professional service charges over and above this insurance payment, as specified by my contract valid at the date of service.**

A photocopy of this Assignment shall be considered as effective and valid as the original.
I authorize the provider to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Patient's Signature_____ **Date:**_____

DYNAMIC REHAB PT PC

55 Meadowlands Pkwy,
Secaucus, NJ 07094

Tel: 973 910 0307
Fax: 718-233-2570

ACKNOWLEDGMENT OF RECIEPT OF HIPAA NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the hospital and the facilities listed at the beginning of this Notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate written explanations of special privacy protections that apply to HIV related information and mental health information.

_____ _____

Signature of Patient or Personal Representative | Print Name of Patient or Personal Representative

_____ _____

Date | Description of Personal Representative's Authority

(For internal use- where signature above cannot be obtained)

Except in emergency treatment circumstances, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we make a good faith effort to obtain written acknowledgment of the patient's receipt of the Notice of Privacy Practices on the first date after April 14, 2003 we provide treatment, products or services to the patient (including at the time of admission, or a first visit to the hospital department, or any first service contact with the patient). We must make a goods faith effort to obtain written acknowledgment when reasonably practicable following an emergency treatment situation. If such acknowledgment cannot be obtained, we must document our good faith effort to obtain the acknowledgment and why it was obtained.

Describe good faith effort to obtain written acknowledgment (including your name and the date)

1. _____

Name: _____ Date: _____

SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Dynamic Rehab PT. PC .** for services furnished to me by provider.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Patient's Signature | Date

_____ _____

Provider's Signature | Date

THE ORIGINAL OF THIS FORM MUST BE PLACED IN THE MEDICAL RECORD

CONSENT/ AUTHORIZATION FORM

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION PLEASE REVIEW IT CAREFULLY.

Dynamic Rehab PT.PC LEGAL DUTY

Dynamic Rehab PT. PC .is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

Consent for Treatment I authorize the above named provider (s), to perform the treatment/procedure(s) described below. I have been informed the reasons for the treatment/procedure(s), along with the expected benefits, risks, possible alternative methods of treatment, and possible consequences involved in the following:

_____

The treatment/procedure(s) were explained to me in detail and all my questions were fully answered. Understanding this, I authorize the above named provider (s) to perform such examinations, treatments, laboratory test, and to administer such medication as in his or her opinion, are necessary or advisable for me (or_____).

Name of Patient if minor

I also certify that no guarantee or assurance has been made as to the results that may be obtained.

Release of Medical Record In order to ensure proper follow-up and continuity of care, I agree that a copy of my medical record may be released to my physician, a designated referral physician, and/or the provider, if any, who referred me here.

Insurance Authorization I request that payment of authorized benefits be made to the above named provider (s) on my behalf, for any services provided to me. I authorize any holder of medical and other information about me to release to Medicare and its agents, any insurance company, any other third party payer, state medical assistant agency, or any other governmental or private payer responsible for paying such benefits, any information needed to determine these benefits for related services. I agree to pay for all charges not covered by a third party payer. I authorize a copy of this authorization to be used in place of the original.

USES AND DISCLOSURES OF HEALTH INFORMATION

Dynamic Rehab PT.PC . uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, **Dynamic Rehab PT.PC** may use your personal health information t o contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you. **Dynamic Rehab PT.PC .** may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes / research studies and for emergencies. We also provide information when required by the law.

CONCERNS AND COMPLAINTS

If you are concerned that **Dynamic Rehab PT.PC** may have violated your privacy rights or if you disagree with any decisions we have made regarding, access or disclose my personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further info on **Dynamic Rehab PT.PC .'s** health information practices or if you have a complaint, please contact Anatoli Yoshovayev, DPT, 55 Meadowlands Pkwy, Secaucus, NJ 07094.

PATIENT INFORMATION CONSENT FORM

I have fully read and understand **Dynamic Rehab PT.PC** Notice of Information practices. I understand that **Dynamic Rehab PT.PC .** may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that **Dynamic Rehab PT.PC .** will consider requests for restriction on a case by case basis, but does not have to agree to request for restrictions.

I hereby consent to the use and disclosure of my personal health information for the purposes as noted **Dynamic Rehab PT.PC** Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at anytime.

Signed:_____ **Date:**_____

Patient or person authorize to consent for patient

DYNAMIC REHAB PT

55 Meadowland Pkwy,
Secaucus, NJ 07094

Tel: 973 910 0307
Fax: 718-233-2570

PATIENT HEALTH HISTORY/ *HISTORIAL MEDICO PACIENTE*

Your Name / Nombre de Paciente_____**Date of Birth /** Fecha de Nacimiento_____

Did you have any surgeries in the past? / *Alguna operación que haya tenido* **YES** */Si* ☐ **NO** ☐

You had any Heart surgeries in the past? / *Sergeries de Corazon en el pasado* **YES** */Si* ☐ **NO** ☐

Did you have Cancer ? / *Tienes Cancer ?* **YES** */Si* ☐ **NO** ☐

Did or do you smoke ? / *Fuma usted ?* **YES** */Si* ☐ **NO** ☐

Do you drink alcohol ? / *Toma alcohol ?* **YES** */Si* ☐ **NO** ☐

Are you pregnant? / *Estan embarazada u ?* ☐ **Not Applicable** **YES** */Si* ☐ **NO** ☐

Did or do you suffer from any of the following conditions?

High Blood Pressure / *Presión alta* **YES** ☐ **NO** ☐

High Cholesterol / *Colesterol Alta* **YES** ☐ **NO** ☐

Hepatitis/Tuberculos **YES** ☐ **NO** ☐

Dizziness / Faintness **YES** ☐ **NO** ☐

HIV/AIDS / *VHS/Sida* **YES** ☐ **NO** ☐

Hernia / *Hernia* **YES** ☐ **NO** ☐

Diabetes **YES/***Si* ☐ **NO** ☐

Lungs/Asthma - Pulmón/Asma **YES/***Si* ☐ **NO** ☐

Arthritis / *Artritis* **YES/***Si* ☐ **NO** ☐

Psychiatric Disorders / *Trastornos psiquiatricos* **YES/***Si* ☐ **NO** ☐

Stroke, Neurological Disease / *Trazo / neurologicas enfermedad* **YES/***Si* ☐ **NO** ☐

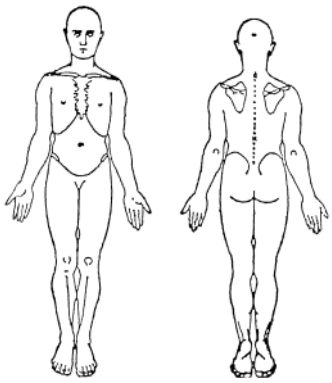
Kidney Problems / *Problemas de rinon* **YES/***Si* ☐ **NO** ☐

Please state all current medications you are taking now / *Haga una lista de MEDICAMENTO que toma:*

_____

Did you have any MRI, CT scans, X-rays, Injections, Doppler, or EMG nerve studies?
Tienes RESONANCIA MAGNETICA / Tomografias Computadas / Rayos X ?
☐ **YES** / *Si* ☐ **NO** **DATA** */ Fecha* _____

On the Body Diagram to the right, mark the area of your pain: ⟶
Encierre algun sintoma que haya



By my signature, I hereby attest that the information in this form is accurate and complete in all respects to the best of my knowledge:

Patient Signature / *Firma del paciente* _____**Date** / *Fecha* _____

DYNAMIC REHAB PT. PC

55 Meadowlands Parkway
Secaucus, New Jersey 07094
Telephone: (973) 910-0307
Fax: (718) 233-2570

Cancellation Policy/No Show Policy For Doctor Appointments

1. Cancellation/ No Show Policy for Doctor Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. If an appointment is not cancelled at least 24 hours in advance you will be charged a twenty dollar ($20) fee; this will not be covered by your insurance company.

2. Scheduled Appointments

We understand that delays can happen however we must try to keep the other patients and doctors on time. If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

3. Account Balances

We will require that patients with self pay balances do pay their account balances to zero (0) prior to receiving further services by our practice. Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns. Patients with balances over $40 must make payment arrangements prior to future appointments being made

Signature: _____ Date: _____

Print name: _____ Chart #:_____

Witness: _____