

PATIENT REGISTRATION

| | | |
|----------------------------|---------------------------|--|
| ADMIT DATE: | Facility Name/Facility #: | INTAKE COMPLETED BY: |
| ACCOUNT #: | | |
| FIRST NAME: * | MI: LAST NAME: * | MARITAL STATUS: M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> U <input type="checkbox"/> |
| STREET ADDRESS: * | ZIP CODE: * | CITY: * |
| HOME PHONE: * | WORK PHONE: | CELL PHONE: |
| SOCIAL SECURITY #: | CO-PAYMENT AMOUNT: | EMAIL ADDRESS: |
| HOW MANY INSURANCE PLANS?: | SEX: | DATE OF BIRTH: * |
| SURGERY DATE: | REFERRING DOCTOR: * | UPIN # _____ |
| BODY PART:* | | NPI # _____ NOTE: Both Required |

PRIMARY INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: *

*Have you received physical therapy, occupational therapy, or chiropractic services in the past year? Yes No

How Many Visits _____

| | | |
|---------------------------------------|-----------------------------------|--|
| INS. COMPANY ADDRESS: | CITY: STATE: | ZIP: PHONE #:* |
| NAME OF INSURANCE POLICY HOLDER: * | INSURED'S SOCIAL SECURITY # | INSURED'S DATE OF BIRTH: |
| INSURED'S POLICY #: * | WORKERS COMP CASE MANAGER NAME: | PHONE #: |
| INSURED'S EMPLOYER: * | EMPLOYER ADDRESS: | EMPLOYER STATE: ZIP: |
| PATIENT INSURANCE GROUP #: | PATIENT INSURANCE POLICY #: | |
| RELATIONSHIP TO INSURED: | EFFECTIVE DATE OF INSURANCE PLAN: | IF AUTO OR WORK RELATED, DATE OF INJURY: STATE: |

SECONDARY INSURANCE INFORMATION

SECONDARY INSURANCE COMPANY NAME:

| | | |
|----------------------------------|------------------------------|--------------------------|
| INS. COMPANY ADDRESS: | STATE: ZIP: | PHONE #: |
| NAME OF INSURANCE POLICY HOLDER: | INSURED'S SOCIAL SECURITY #: | INSURED'S POLICY #: |
| | INSURED'S DATE OF BIRTH: | |
| PATIENT INSURANCE GROUP #: | PATIENT INSURANCE POLICY #: | RELATIONSHIP TO INSURED: |

Do you have an attorney for this injury? Yes No

Have you had home health care prior to physical therapy? Yes No If yes date discharged _____

RX DATE:* _____ **FREQ & DURATION** _____ **THERAPIST** *

PATIENT SIGNATURE _____ **DATE** _____

AON PHYSICAL THERAPY AND WELLNESS PATIENT RESPONSIBILITIES

AON Physical Therapy and its staff wish to provide you with exceptional care. The goal of AON Physical Therapy and Wellness is to continuously exceed your expectations, and those of your referring physician. In order to achieve this goal, AON asks that you please adhere to the following guidelines:

- **Proper attire for Physical Therapy office visits includes shorts, T-shirts, and sneakers for lower back, hip, knee, ankle and foot patients. Neck, shoulder, and upper extremity patients should wear loose fitting short sleeved shirts. Wearing the proper attire will allow the clinical staff to furnish you with excellent care in a safe and comfortable manner. For your convenience AON PT and Wellness has changing rooms on site.**
- **Upon arrival for your office visit please do not enter the treatment area prior to signing in and checking with the front desk.**
- **Cell phone use inside the office is strictly prohibited except for emergency purposes.**
- **Please be on time for your office visit. Patients that are early or late place a strain on the clinic and potentially compromise the care of our other patients. If you can not be on time, please call to inform us of your situation. The office staff will make every effort possible to accommodate your scheduling needs. Failure to call will make meeting you needs significantly more difficult.**
- **If you must cancel and office visit please try to notify us no later than 24 hours in advance. AON reserves the right to charge patients for continuous no-shows or excessive cancellations of appointments.**
- **You must meet you co-payment or co-insurance obligation at the time of each visit. These fees are part of your contractual agreement with your insurance company. Please request a receipt as proof of payment.**

Thank You for choosing AON Physical Therapy needs. We hope that your experience is an enjoyable one. If you should have any feedback or suggestions please feel free to call or submit them in writing to:

Lee Day /Owner, AON Physical Therapy and Wellness
185 Route 312 Suite 301B
Brewster, New York 10509
(845)279-9288 PHONE

X _____

Patient Signature

Patient Medical History

Name: _____ Referring Physician: _____

Family Physician: _____ First Doctor Visit for this injury: _____

Last date worked due to this injury: _____ Date returned to work after this injury: _____

Is there an attorney involved with this case? _____ Date of next doctor visit: _____

Have you had surgery for this injury? _____ Number of Surgeries: _____ Date(s) _____

Type of Surgery: _____

Where did your surgery take place: _____

Current Level of Pain (0 being no pain, 10 being pain requiring Emergency Room care)

(Circle only one) 1 2 3 4 5 6 7 8 9 10

ARE YOU CURRENTLY TAKING ANY PRESCRIPTION OR OVER THE COUNTER MEDICATIONS: _____

If yes, please list: _____

PLEASE CHECK ANY OF THE FOLLOWING MEDICAL OR REHABILITATIVE SERVICES YOU HAVE RECEIVED FOR THIS CONDITION

| | | | |
|----------------------------|------------------------|---------------------------|----------------------------|
| _____ Orthopedist | _____ Physical Therapy | _____ X-rays | _____ EMG |
| _____ Occupational Therapy | _____ CT Scan | _____ NCV | _____ Neurologist |
| _____ Massage Therapy | _____ MRI | _____ Injection | _____ General Practitioner |
| _____ Myelogram | _____ Cast or Brace | _____ Emergency Room Care | |
| _____ Chiropractor | _____ Other: _____ | | |

PLEASE CIRCLE ANY OF THE FOLLOWING ITEMS THAT PERTAIN TO YOUR HEALTH HISTORY

| | | | |
|-----------------------|--------------------------|-----------------------|-----------------------------|
| Asthma | Sleeping Problems | Allergies | Shortness of Breath |
| Emotional | Psychological | Anemia | Coronary Heart Disease |
| Headaches | Infectious Disease | Chest Pain | Numbness or Tingling |
| Neurological Problems | Do you have a Pacemaker? | Dizziness or Fainting | Diabetes |
| High Blood Pressure | Blurred Vision | Metal Implants | Heart Attack |
| Ringing in the ears | Cancer | Heart Surgery | Weakness |
| Do you Smoke? | Stroke or TIA | Weight loss | Arthritis or Swollen Joints |
| Blood Clot or Emboli | Night Sweats | Are you Pregnant? | Epilepsy or Seizures |
| Hernia | Osteoporosis | Thyroid Trouble | Varicose Veins |

Other: _____

PLEASE LIST ANY SURGERIES YOU HAVE HAD IN THE PAST: _____

PLEASE LIST THREE GOALS YOU WOULD LIKE TO ACHIEVE WHILE IN THERAPY:

1. _____
2. _____
3. _____

EMERGENCY CONTACT: _____ PHONE: _____

PATIENT OR GUARDIAN SIGNATURE: _____ Date: _____

Notice of Privacy Practices for AON Physical Therapy and Wellness

At AON Physical Therapy and Wellness, we are dedicated to providing top-quality service and physical rehabilitation treatment. Protecting your privacy is of paramount importance to us, and we have implemented procedures to safeguard the information included in your files.

The notice describes how Protected Health Information (PHI) about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Personal and Protected Health Information:

We may gather personal and health information from you, other health care providers and third party payers. This information is used for treatment, payment and health care operations. The following describes the ways we may use and disclose your Protected Health Information:

- We may provide PHI about you to health care providers, other practice personnel, or third parties who are involved in the provision, management or coordination of your treatment care.
- We may disclose your PHI to any third party you designate in writing.
- We may use or disclose your PHI so that we can collect or make payment for the health care services you receive or are going to receive.
- We may disclose your PHI if we believe it is necessary to prevent a serious threat to your health and safety or the health and safety of the public.
- We may disclose your PHI to a government agency if we believe you have been a victim of abuse, neglect or domestic violence. We will make this disclosure if it is necessary to prevent serious harm to you or other potential victims, you are unable to agree to your incapacity, you agree to the disclosure, or required by law.
- We may disclose your PHI to a health oversight agency for activities authorized by law.
- We may disclose your PHI as required by a court or administrative order, or under certain circumstances in response to a subpoena, discovery request or other legal process.
- We may release your PHI as necessary to comply with laws relating to Worker's Compensation or similar programs that are established by the law to provide benefits for work-related injuries or illness without regard to fault.
- Your PHI may be disclosed for military and veterans affairs, for national security and intelligence activities, or for correctional activities.
- We may use or disclose your PHI when required by law.
- We may use your name, address, phone number, e-mail, and your records to contact you with appointment reminder calls, recall postcards, greeting cards, information about physical rehabilitation, or other related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

Please note your rights regarding this information:

1. You are entitled to inspect and receive copies of your records upon written request.
2. You are entitled to make a written request to amend your PHI files or put restrictions on certain uses and disclosure of PHI.
3. We accommodate any reasonable request, yet we retain the right to deny inclusion of amendments or use restrictions of your PHI.
4. You have a right to receive all notices in writing.
5. You have the right to request that we do not disclose your information to specific individuals, companies, or organizations. Any restrictions should be requested in writing. We are not required to honor these requests, if we agree with your restrictions the restriction is binding on us.

If you have any questions regarding your HIPAA Privacy rights, please contact our office.

This notice remains in effect until it is replaced or amended by changes in the law.

X

Patient Signature