BACK TO HEALTH PT, PC
2004 SEAGIRT BLVD, FAR ROCKAWAY, NY 11691

REGISTRATION INFORMATION

Date : _____ Home Phone: _____ Alt. Phone: _____
Patient: _____

Responsible Party (if a minor): _____

Address: _____

City: _____ State: _____ Zip: _____

Sex: _____ Date of Birth _____ Age _____ Single___ Married__ Widowed___ Separated___ Divorced___

Social Security # _____ Spouse's Social Security # _____

Patient Employed By: _____

Business Address: _____

Occupation: _____ Business phone _____

Spouse (or responsible party) Name : _____ Date of Birth _____

Business Name And Address of Spouse: _____

Occupation: _____ Business phone _____

Who Is Responsible For This Account? _____ Relationship to patient _____

Do you Have Medical Insurance? _____ No _____ Yes, if yes, please provide the name of primary insurer

Name Of Primary Insurer _____

Contract # _____ Group # _____ Subscriber # _____

Name Of Secondary Insurer (if any) _____

Contract # _____ Group # _____ Subscriber # _____

____Medicare ID # _____ Claim ID # _____ Medicaid Claim ID # _____

If Welfare, your case number _____ County of _____

In case of emergency, who should be notified? _____ Phone _____

How did you learn of our practice? _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____
Name of Insurance Company

and assign directly to Dr. Mark Vaysman all medical benefits, if any, otherwise payable to me for services rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

X _____ _____
Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. PT-Evaluation for any services furnished me by that physician. I authorize any holder of medical information about me to release the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms of electronically submitted claims, my signature authorizes releasing of the information to the insurer of agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

X _____ _____
Beneficiary's Signature Date

BACK TO HEALTH PT, PC
2004 SEAGIRT BLVD
FAR ROCKAWAY, NY 11691
718.868.8668

PERMISSION FOR TREATMENT

I hereby authorize BACK TO HEALTH PHYSICAL THERAPY, PC or its representatives to provide medical and or dental care, such as: to conduct routine examinations, to obtain specimens, including blood, to perform such tests and administer treatments, including the injection of all pharmaceutical products (medications) and immunizations to myself or my minor child (print name)_____ as may be deemed necessary now and on subsequent visits.

_____
Date

_____
Signature

_____
Relationship

IN AN EMERGENCY NOTIFY:

_____
Name

_____
Address

_____
Phone Home

_____
Phone Work

BACK TO HEALTH, PT, PC
2004 SEAGIRT BLVD
FAR ROCKAWAY, NY 11691
718.868.8668

PATIENT HIPAA AWARENESS

With my awareness, BACK TO HEALTH PT may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to BACK TO HEALTH PT 's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of, Privacy Practices prior to signing this consent. BACK TO HEALTH PT reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of BACK TO HEALTH PT may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including
laboratory results among others.

With my permission, the office of BACK TO HEALTH PT, may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my permission, the office of BACK TO HEALTH PT may e-mail to my home or other designated location any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements. I have the right to request that BACK TO HEALTH PT restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing BACK TO HEALTH PT to use and disclose my for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____
Signature of Patient or Legal Guardian

_____ _____
Patients Name Date

_____
Print Name of Patient or Legal Guardian

BACK TO HEALTH PHYSICAL THERAPY, PC

ACKNOWLEDGEMENT OF RECIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ DOB:__/__/__

I have been presented with a copy of BACK TO HEALTH PHYSICAL THERAPY, PC

Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand and agree with the contents of the Notice.

_____ _____

Patient or Legal Representative Signature Date

If not signed by the patient, please indicate relationship to patient.

_____ _____

Relationship Signature of Witness

For office staff use only:

If patient or patient's representative refuses to sign the acknowledgement, document the date notice was presented to the patient and the reason(s) patient or patlent's representative refused to sign.

Notice was presented on (date):_____

Signature was not obtained because:_____

_____

Staff Member Presenting the Notice:_____ _____

Name Title

BACK TO HEALTH PT, PC

FINANCIAL AGREEMENT

Patient Name:_____ DOB: ___/__/__

1. I understand that **BACK TO HEALTH PT, PC** will bill my health insurance and/or me for services they provide.
2. I agree to assist **BACK TO HEALTH PT, PC** in securing any third party (insurance) payments for the services which I have received.
3. I agree to provide **BACK TO HEALTH PT, PC** will current insurance information to assist in collecting payment for services provided.
4. I agree to update **BACK TO HEALTH PT, PC** should any insurance information change.
5. I understand that I may be responsible for any co-payment of balances if my insurance does not cover the full amount billed.
6. I understand that if I do not have insurance I will be charged for services. Payment is expected at the time of service.
7. My signature below authorizes **BACK TO HEALTH PT, PC** to release to my health insurer any protected health information needed process claims for service provided.

SIGNATURE ON FILE

I request that payment of authorized benefits be made on my behalf to **BACK TO HEALTH PT, PC** for services furnished to me by their providers. I authorize any holder of my protected health information to release Medicare, Medicaid or my commercial insurance carrier any information to determine these benefits or the benefits payable for related services.

_____ __/__/__
Guarantor's Signature (Patient / Legal Guardian) Date

_____
Print Name

PATIENT'S MEDICARE AUTHORIZATION

PATIENT'S NAME:_____

PATIENT'S MEDICARE NO.:_____

I request that payment of authorization Medicare benefits be made to Dr. _____or _____ for any services furnished be by that physician/supplier.

I authorize any holder of medical information about me to release to the Health Care Financing Administration any information needed to process claims relating to paying benefits for the services rendered.

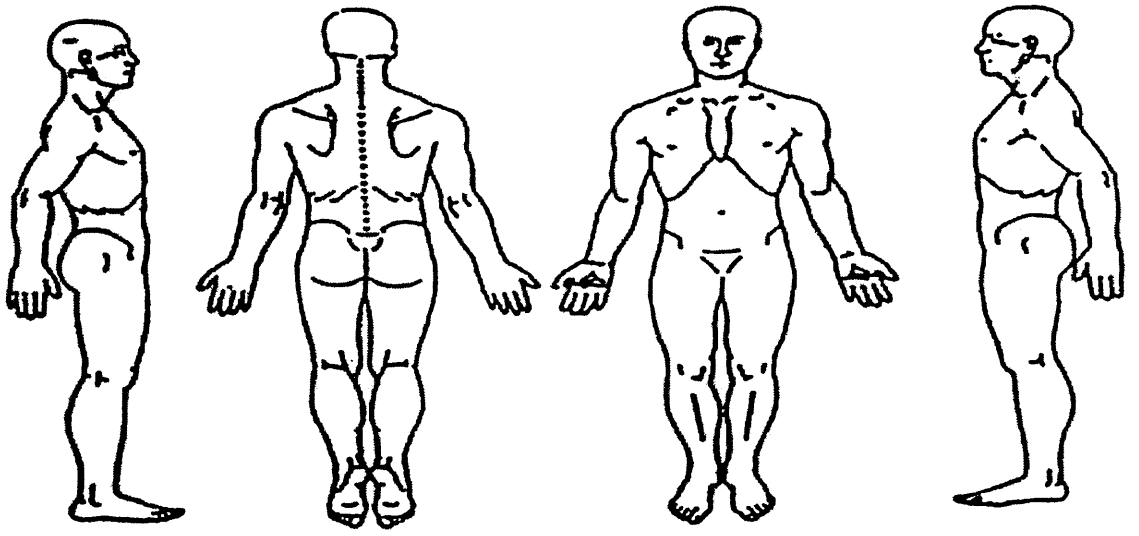
I understand my signature authorizes payment to be made to Dr._____ or _____ based upon services rendered by them. I also authorize release of information to any other carrier involved in the payment of a particular claim.

I understand Dr. _____or _____ is accepting Medicare assignment and agrees to accept the approved fee schedule as defined by Medicare (HCFA) as the full charge (approved amount).

I understand that I am responsible only for the annual deductible, any applicable co-insurance, and non-covered services rendered as defined by A Medicare (HCFA).

PATIENT'S SIGNATURE: _____

DATE: _____



Please clearly indicate by circling where your pain is located using the picture above.

What best describes your pain?

Sharp_____ Dull Ache_____ Numb_____ Shooting_____ Burning_____ Tingling_____

How often do you experience symptoms?

Constantly(76-100%)_____ Frequently(51-75%)_____ Occasionally(26-50%)_____ Intermittently(>25%)_____

Instructions: Rate your major area of pain on the 0-10+ pain rating scale with Zero(0) being no pain at all and ten(10+) being the worst possible pain you could EVER imagine. Write the number of pain at the present time and you best day and your worst day over the past 30 days.

- Pain NOW _____/10+
- Pain at it's best _____/10+ It gets better when _____
- Pain at its's worst _____/10+ It gets worse when_____

***Are your symptoms?**(check one) Getting worse_____ The same_____ Improving_____

***Are you currently?**(check all that apply) Pregnant_____ Depressed_____ Under stress_____

***How are you able to sleep at night?** (check one) Fine_____ Moderate difficulty_____ With medication_____

Have you or an immediate family member ever been diagnosed with? (Circle YES or NO)

	SELF	FAMILY		SELF	FAMILY
Cancer	yes...no	yes...no	Diabetes	yes...no	yes...no
High blood pressure	yes...no	yes...no	Heart disease	yes...no	yes...no
Angina/chest pain	yes...no	yes...no	Stroke	yes...no	yes...no
Osteoporosis	yes...no	yes...no	Osteoarthritis/Rheumatoid	yes...no	yes...no

Do you have a history of? (Circle YES or NO)

Allergies/asthma	yes...no	Headaches	yes...no
Bronchitis	yes...no	Kidney disease	yes...no
Rheumatic fever	yes...no	Seizures	yes...no
Ulcers	yes...no	Sexually transmitted disease	yes...no

In the past 3 months have you had or do you experience any of the following?(Circle YES or NO)

A change in your health	yes...no	Nausea/Vomiting	yes...no
Fever/chills/sweats	yes...no	Unexplained weight change	yes...no
Changes in appetite	yes...no	Difficulty swallowing	yes...no
Urinary tract infection	yes...no	Shortness of breath	yes...no
Dizziness	yes...no	Upper respiratory infection	yes...no
Change in bowel function	yes...no	Change in bladder function	yes...no

Do you have a problem with? (check all that apply)
Hearing_____ Vision_____ Speech_____
Communication_____

Do you or have you in the past smoked tobacco?
YES_____ NO_____
If yes, _____packs per _____ for _____ years.
Last Tobacco use
_____

Do you drink alcoholic beverages?
YES_____ NO_____
If yes, how many drinks do you routinely have per week? _____/week

Date of last physical examination?
_____

Have you been hospitalized for you problem?
YES_____ NO_____ Date_____

Have you had surgery for your problem?
YES_____ NO_____ Date_____

Have you had any of these diagnostic tests for your problem?
X-rays_____ MRI_____ CT scan_____
Other_____

Please list 3 important activities that you are unable to do or that you are having difficulty doing as a result of your problem with zero(0) being unable to perform the activity and ten (10) being able to perform the activity pre-injury level.

Activities:	Unable										Normal
1._____	0	1	2	3	4	5	6	7	8	9	10
2._____	0	1	2	3	4	5	6	7	8	9	10
3._____	0	1	2	3	4	5	6	7	8	9	10

Surgical History: (please list ALL surgeries and their dates)

_____
_____
_____
_____
_____
_____
_____

Documentation of Current Medication (please list all including prescription, over-the-counter, vitamins, etc.)

NAME	***DOSAGE***	***HOW OFTEN***

Signature_____ Date_____