PATIENT QUESTIONNAIRE
FOR PHYSICAL THERAPY CLIENTS

GENERAL PATIENT INFORMATION

First and Last Name: _____ Middle Initial:_____

Nickname: _____

Date of birth (mm/dd/yyyy): _____ Age: _____

Sex (circle one): Male / Female Height: _____ Weight: _____ Blood Pressure: _____

Marital Status (circle one): Married / Single / Divorced / Widowed

Occupation: _____

Street Address: _____ City: _____

State: _____ Zipcode: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Emergency Contact Name: _____ Emergency Phone: _____

Referred to Sky Health Physical Therapy by: _____

If Referred from Surgery, Referring Physician: _____

Surgery Date: _____ Body Part / Area Affected: _____

Is your condition related to a work accident? Yes / No

Or an automobile accident? Yes / No

Have you had Physical Therapy this year? Yes / No

INSURANCE INFORMATION

Employer: _____

Primary Insurance Provider: _____

Insurance Phone: _____

Name of Insurance Policy Holder: _____

Relationship to the Insured: _____

Insurance Policy Number: _____ Group Number: _____

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MEDICAL HISTORY

Are you currently pregnant or think you might be pregnant? Yes / No

Do you have a pacemaker? Yes / No **Are you latex sensitive?** Yes / No

Do you now have, or have you recently had any of the following conditions? (Check all that apply)

__Fatigue
__Fever / Chills / Sweats
__Nausea / Vomiting
__Weight Loss / Gain
__Balance Issues
__Falls
__Numbness or Tingling
__Muscle Weakness
__Dizziness / Lightheadedness
__Heartburn / Indigestion
__Difficulty Swallowing
__Issues with Bladder Bowel
__Constipation
__Diarrhea
__Shortness of Breath
__Fainting
__Cough
__Headaches

Have you EVER been diagnosed with any of the following conditions? (Check all that apply):

__Cancer
__Liver Problems
__Osteoporosis
__Tuberculosis
__Ashthma
__Epilepsy
__Rheumatoid Arthritis
__Other Arthritic Conditions
__Depression
__Heart Problems
__Kidney Problems
__Multiple Sclerosis
__Chemical Dependency
__Anemia
__Diabetes
__Stroke
__Thyroid Problems
__Lung Problems
__Chest Pain / Angina
__High Blood Pressure
__Circulatory Problems
__Blood Clots
__HIV

PATIENT QUESTIONNAIRE FOR PHYSICAL THERAPY CLIENTS

DESCRIPTION OF SYMPTOMS

Date of symptoms onset: _____

Did something cause the commencement of symptoms? If so, please describe: _____

_____

_____

Are symptoms improving, unchanging, or worsening? _____

Using a 0 to 10 scale, 0 being “no pain” and 10 being “worst pain imaginable,”

please rate your symptoms at their:

Present State: _____ Best State: _____ Worst State: _____

What activities aggravate your symptoms? _____

What activities lessen your symptoms? _____

Please list any recent surgeries or conditions for which you have been hospitalized, including the date:

_____

Please list any tests that have been performed for your condition or symptoms (x-ray, MRI, labs):

_____

Please list any medications you are currently taking (including pills, injections, and/or skin patches):

_____

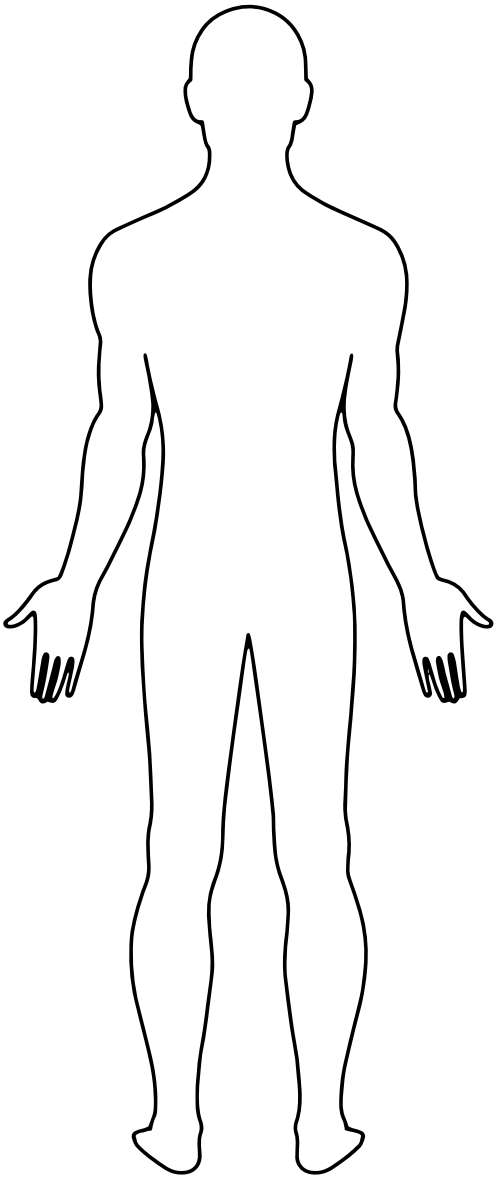
Please list any allergies that you have:

_____

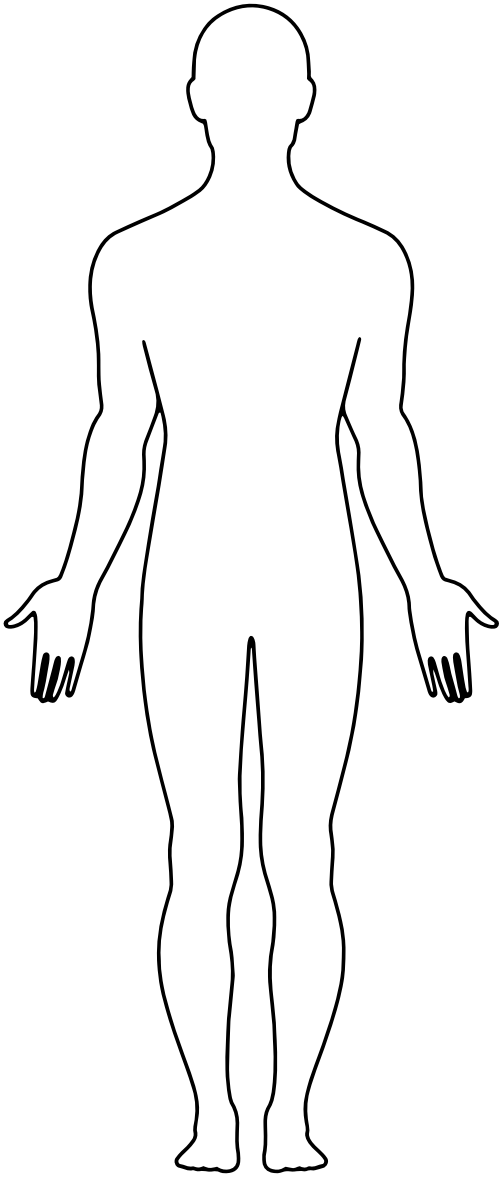
SYMPTOMS LOCATION

Use the body chart below to identify where your symptoms are located, applying the following symbols to indicate the type of symptom you are experiencing (**x** for shooting sharp pain; ***** for dull / aching pain; **o** for numbness; and **=** for tingling).

FRONT



BACK



Print Name: _____

Signature: _____

Date: _____

PATIENT AUTHORIZATIONS, ASSIGNMENTS & ACKNOWLEDGEMENTS

RELEASE OF INFORMATION

Sky Health NYC is authorized to release any medical information needed to process applications for financial coverage for services rendered during the visits of the patient named below.

This information may be released to third party payers and others assisting Sky Health NYC in obtaining payment including billing, coding and collection agents and to its attorneys and consultants or to any employer as necessary to secure payment.

I / we further authorize Sky Health NYC to release medical records / information to his / her referring physician.

PERSONAL VALUABLES

Sky Health NYC will not be liable for loss or damage to money, jewelry, documents or articles of value while the patient is present on it's premises.

ASSIGNMENT OF INSURANCE BENEFITS

Medical treatment has or will be provided to the patient named below. I / we assign, transfer and convey to Sky Health NYC all of my / our rights, title and interest to all of the medical insurance benefits to which I / we may be entitled according to my / our insurance policies with the companies noted to the extent necessary to provide for payment of the patient's bill.

GUARANTEE OF PAYMENT / FINANCIAL RESPONSIBILITY

If the patient's insurance benefit is insufficient to pay all of the medical care rendered to the patient named below or the patient has no insurance, I understand that I am fully responsible for the balance due, based upon Sky Health NYC charges which I agree are fair and reasonable.

I / we understand that any balance after insurance reimbursement, is my / our responsibility. I / we agree to pay the balance within 30 days of receipt of invoice or Sky Health NYC to arrange a payment plan. Failure to respond as outlined above will result in the account being turned over to a collection agency. All balances in excess of 90 days are subject to a monthly finance charge of 1.5%.

I agree to not contest credit card charges that I approved, after the fact.

SPECIAL NOTICE TO PATIENTS SEEING A PHYSICAL THERAPIST WITHOUT A PHYSICIAN'S PRESCRIPTION – "DIRECT ACCESS"

"Notice of Advice" as per the Office of the Professions of New York State Education Department: "At the beginning of physical therapy treatment without a referral, the physical therapist must advise the patient in writing of the possibility that the treatment may not be covered by the patient's healthcare plan or insurer without a referral from a physician, dentist, podiatrist, or nurse practitioner; and, treatment may be a covered expense if rendered with a referral."

HIPAA ACKNOWLEDGEMENT

I / we hereby acknowledge that I / we have received a copy of the Notice of Privacy Practices as required by the Federal Health Insurance Portability and Accountability Act (HIPAA).

HIPAA PRIVACY NOTICE

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

INTRODUCTION: We are required by law to maintain the privacy of "protected health information." "Protected Health Information" includes any identifiable information that we obtain from you or others that relates to your physical or mental health, the health care you have received, or payment for your health care.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. This notice also discusses the uses and dis-closures we will make of your protected health information.

We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at the time. We will provide you with any Revised Notice of Privacy Practices at the time of your next appointment.

PERMITTED USES AND DISCLOSURES: As provided by law, we can use or disclose your protected health information for purposes of treatment, payment and health care operations. If you refuse to consent, we do not have to provide you with non-emergency care.

Treatment means the provision, coordination or management of your health care, including consulta-

tions between health care providers regarding your care and referrals or health care from one health care provider to another. For example, your protected health information may be provided to a physician who referred you to our practice to ensure that the physician has all of your medically necessary information.

Payment means activities we undertake to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and utilization review activities. For example, prior to providing healthcare services, we may need to provide to your insurance company information about your medical condition to determine whether the proposed course of treatment will be covered. When we subsequently bill the insurance company for the services rendered to you, we can provide the insurance company with information regarding your care if necessary to obtain payment.

Health care operations means the support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your medical information to evaluate the performance of our staff when caring for you. We may also combine medical information about patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective.

OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

When we determine, in our professional judgment, that it is in your best interest, we may disclose your protected health information to your family or friends when they are involved in your care or the payment of your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment.

We will allow your family and friends to act on your behalf to pick up filled prescriptions, medical supplies, x-rays and similar forms of protected health information, when we determine, in our professional judgment, that it is in your best interest to make such disclosure.

We will share your protected health information with third party “business associates” that perform various activities (e.g. Answering service) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a

written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required by law: We may use or disclose your protected health information to the extent that law requires the use of disclosure. The use of disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Disease: We may disclose protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system government benefit programs, other government regulatory programs and civil right laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products to enable product recalls, make repairs or replacements, or to conduct post marketing surveillance as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request, or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, law enforcement purposes. These law enforcement purposes include: 1) legal processes and otherwise required by law, 2) limited information requests for identification and location purposes, 3) pertaining to victims of a crime, 4) suspicion that death has occurred as a result of criminal conduct, 5) in the event that a crime occurs on the premises of the practice and 6) medical emergency (not on Practice's premises) and it is likely that a crime has occurred.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel: 1) for activities deemed necessary by the appropriate military command authorities, 2) for the purpose of determination by the Department of Veterans Affairs of your eligibility for benefits, 3) to foreign military authority if you are a member of that foreign military service. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of the protective services to the President or others legally authorized.

Except for the general uses and disclosures described above, we will not use or disclose your protected health information for any other purpose unless you provide a written authorization. You have the right to revoke that authorization in reliance on your authorization.

YOUR RIGHTS:

1. You have the right to request restrictions on our uses and disclosures of protected health information for treatment, payment and health care operations. However, we are not required to agree to your request.

2. You have the right to reasonably request to receive communications of protected health information by alternative means or at alternative locations.

3. You have the right to inspect and copy the protected health information contained in your medical and billing records and in any other Practice records used by us to make decisions about you.

4. You have the right to request and receive a paper copy of this notice from us.

COMPLAINTS:
If you believe that your privacy rights have been violated, you should immediately contact the office manager at our Practice. We will not take action against you for filing a complaint. You also may file a complaint with the Secretary of Health and Human Services.

PATIENT CONTACT POLICY
Claude Hillel PT may contact the patient via email or phone call in regard to coordinating appointments, appointment reminders/confirmations/changes, or to discuss your treatment. Claude Hillel PT may occasionally send out a newsletter with athletic training tips, partnership discounts, and health information. Your information will never be disclosed or shared, and cannot be under the law.

PATIENT CONSENT
I do hereby authorize Claude Hillel PT to furnish me (or the patient-minor mentioned above) with medical and physical care and treatment that is considered necessary and proper in diagnosing and/or treating my (or the patient-minor's) physical condition including, but not limited to, diagnostic x-rays, the administration and/or injection of medication and pharmaceutical products, and the drawing of blood, as in the judgement of personnel and/or physicians of Claude Hillel PT deem necessary.

I acknowledge that no guarantees or assumptions have been given to me concerning the results or findings intended from the treatment or examination at Claude Hillel PT. I confirm that I have read and fully understand the above, and have been given the opportunity to ask questions and that all my questions have been answered fully and to my satisfaction.

This consent will cover every visit made by me (or the patient-minor) as long as I (or patient minor) remain an active patient of Claude Hillel PT.

Medical exam and physical therapy of injuries will involve touching the patient and manipulation of body parts. Everyone has a different tolerance for touch; we ask that you speak to your treating provider if you are at all uncomfortable with touch. Your treating therapist will explain any touch to you prior to touching you and will use towels to cover sensitive areas. It there is anything about the proposed therapy that makes you feel uncomfortable, or anything about the therapy that is uncomfortable as it progresses, you should stop the treatment and speak to your provider or to a practice manager.

It is very common for a provider to treat areas that they feel are deficient and that don't readily seem con-

nected to your injury (a common example of this is a PT treating a psoas when presented with the complaint of knee pain). Your PT is trained to consider all causes of pain, and will treat you holistically.

ATTENDANCE AND CANCELLATION POLICY

Claude Hillel PT strives to provide each patient with the highest quality of care while also attempting to accommodate your schedule to the greatest extent possible. Therefore, we provide reserved time slots for each patient with a specific therapist in order to minimize waiting times and assure continuity of your personal treatment. Your consistent attendance of the planned treatment regimen is vital to your full recovery.

Last minute cancellations or no-shows decrease our ability to accommodate the scheduling needs of other patients and hinder your treatment plan.

If you are unable to keep a scheduled appointment, we request that you notify our office at least 24 hours in advance of your scheduled appointment time by sending an email to claude@skyfitnyc.com. If you do not attend a scheduled appointment and do not give at least 24 hour cancellation notice, you will be charged a $100.00 cancellation fee, which must be settled before your next appointment. We consider your appointment effectively cancelled if you are more than 15 minutes late for your scheduled time.

All cancellations and no-shows will be documented in our medical records and appropriately reported to your physician and insurance/third-party payer. Should you accumulate 2 or more cancellations or no-shows, your therapist may refer you back to your physician before scheduling another appointment or may choose to discharge you from therapy and report this to your physician.

Your adherence to this policy will ensure that you and all of our other patients receive the best quality of care, and we thank you in advance for your cooperation.

CONTACT INFORMATION

For scheduling, billing, insurance or general information, email Claude Hillel at claude@skyfitnyc.com. Emails are usually answered within 24 hours.

STANDARD OF CARE

Claude Hillel PT employs licensed and insured physical therapists who are highly experienced in outpatient orthopedics and have demonstrated competent clinical decision-making, are skilled in manual therapy, and professionally abide by the American Therapy Association's Guide to Physical Therapy Practice and the New York State Practice Act and Code of Professional Conduct.

PATIENT AUTHORIZATIONS, ASSIGNMENTS & ACKNOWLEDGEMENTS

FEE SCHEDULE AND PAYMENT POLICY

Initial 1 hour evaluation: $200 per session
1 hour follow-up visits: $150 per session

Out-of-network insurance reimbursement is available to those individuals whose policies qualify. If you wish to apply our fee to your insurance policy, your benefits will be verified, and an agreement of payment structure will be agreed upon prior to the commencement of service. You are solely responsible for payment for services and accept your insurance policy's modes of operation.

OUT-OF-NETWORK PROVIDER BILLING ENDORSEMENT AGREEMENT

Claude Hillel PT does not participate "in-network" with my health insurance company and is considered an out-of-network provider. Benefits vary greatly among plans. Claude Hillel PT will seek information from my health insurance company in advance as to whether insurance coverage exists for physical therapy treatment and the extent of coverage.

I have been informed by Claude Hillel PT that they will be filing a claim to my health insurance company for physical therapy services. Furthermore, I have been informed that these treatments will be billed as "out-of-network" services. I, as the patient, am ultimately responsible for any and all outstanding amounts which are not reimbursed by my health insurance company, including co-insurance and deductibles.

I understand that checks for these services will be made payable to the policyholder, i.e. spouse, guardian or patient. By checking the box below, I agree to endorse the back of aforementioned check/checks and include the words "pay to the order of Claude Hillel PT" above my signature. I also am aware that I have the option of depositing the check or checks into my bank account and then writing a personal check to Claude Hillel PT for the exact amount originally written out to the insured. I also agree to present or mail these check to Claude Hillel PT located at 251 5th Avenue, 7th Floor, NY, NY 10016 immediately after they are received from my health insurance company. When mailing or presenting these checks I will include the insurance company's explanation of benefits so Claude Hillel PT can verify that my claims were processed correctly.

I understand that failure to do so will result in a violation of this agreement and I, (the patient, not the insured), will be billed and directly responsible for the entire original balance originally billed to the insurance company.

CONSENT

By signing below, I verify that I have read and agree to all of the provisions above and that the information I have provided is true and accurate.

Signature: _____ Date: _____