MOVING FORWARD
PHYSICAL THERAPY, P.C.
30 East 60th Street, STE 505
New York, NY 10022
P. 888.705.2227
F. 888.705.2297
MOVINGFORWARDPT.NYC

New Patient Registration Form

Personal Information

First Name:		Last Name:	
Address 1:		Address 2:	
City/State		Zip:	
Home #:		Work #:	
Cell #:		Fax #:	
Date of Birth:		SSN:	
Email:			
Emergency Contact Name:		Phone #:	
Relation to Patient:			

Insurance Information

Plan Name:		Member ID:	
Policy #:		Group #:	
Policy Holder Name:		Policy Holder DOB:	
Relation to Patient:	Self Child Guardian Spouse/Partner		

Referral Information

How did you hear about Moving Forward Physical Therapy? Google Web LinkedIn MD/DO/DPM Twitter			
Friend:		Other:	
Referring Physician:			

Appointment Reminders Please indicate your preferred method of contact:

Email:		Text:	

Email Consent

New regulations require that anyone using email to communicate with healthcare providers understand and agree to certain conditions and limitations.

1. The transmission of patient information via email has a number of risks including but not limited to: email is not secure; email can be intercepted, misaddressed, altered, forwarded, or used without authorization or detection; email may be circulated, forwarded and stored in paper and electronic files even after the sender or recipient has deleted his or her copy.
2. The Practice will use all reasonable means to protect the security of the email, however we cannot guarantee email confidentially. The Practice is not liable for improper disclosures unless they are caused by the Practice's intentional misconduct.

I have read and understand the email disclaimer and give consent to Moving Forward Physical Therapy, PC to correspond with me via email, if necessary.

Patient Signature:_____ **Date:** _____

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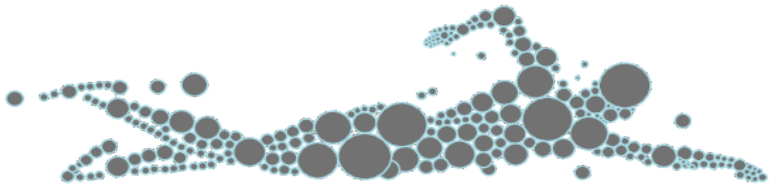

PHYSICAL THERAPY PATIENT AGREEMENT

Thank you for choosing Moving Forward Physical Therapy, P.C. Please read and sign the following agreement; it explains our billing, scheduling and cancellation policies. If you have any questions, we will be glad to answer them.

- All patients of Moving Forward Physical Therapy, P.C. must at some point obtain a valid, written prescription from a medical doctor, osteopath or podiatrist.
- In order to achieve maximum therapeutic benefit from physical therapy you must attend regularly scheduled appointments and adhere to the home exercise program assigned to you. If you have difficulty with your home exercises, please discuss this with your therapist.
- Patients are responsible for scheduling and confirming appointments with the front desk. If you cannot make a scheduled appointment it must be canceled at least 24 hours in advance or a cancellation fee equal to the full price of the appointment will be assessed. Similarly, if you do not show up for a scheduled appointment, a cancellation fee equal to the full price of the appointment will be assessed. This fee is not billable to any insurance carrier. We reserve the right to remove you from the treatment schedule if you cancel without 24 hours' notice or if you do not show up for your appointments 3 consecutive times.
- Payment of all fees is expected at time of service or via credit card on file. We will assist you in submitting claims to your insurance carrier. However, you are still responsible for any deductible, co-insurance/co-payments or claim(s) denied by your insurance carrier. Should your account go into arrears, all attorney fees will be charged in addition to your outstanding balance.
- Lockers are available for your use at your own risk. Moving Forward Physical Therapy P.C. shall not be liable for the disappearance, loss, theft of, or damage to your personal property: this would include money, negotiable securities, furs or jewelry.

I hereby authorize Moving Forward Physical Therapy, P.C. having treated me, to release to government agencies, insurance carriers, and all others who are financially liable for my care, all information needed to substantiate payments for care and to permit representative thereof to examine and make copies of all records related to such care and treatment. I understand that if, at any point, my insurance coverage changes, I am to notify the staff prior to my next visit. Failure to do so will result in my being responsible for the full amount of services.

I have read, understand and agree to all the above policies and procedures and voluntarily consent to physical therapy treatment.

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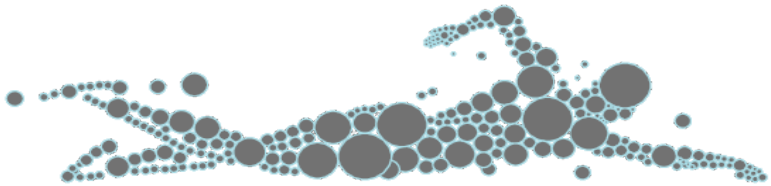

CREDIT CARD AUTHORIZATION

Moving Forward Physical Therapy, P.C. requires that you provide a credit card to have to file (see below for details).

Card Type:	AMEX	VISA	MC	DISC
Card No:				
Exp Date:		3 Digit Sec. (4 in front if Amex):		
Name on Card:				
Billing Address 1:				
Billing Address 2:				

I hereby authorize, Moving Forward Physical Therapy P.C. to charge my credit card account for fees related to rendered services. These fees include but are not limited to missed co-pays/co• insurances, deductibles, reimbursed yet un-endorsed checks from my insurance. I understand that I will be able to provide payment through the method of my choice on current balances. However, outstanding balances that are past due 30 days will be charged to the credit card on file unless other arrangements have been made.

This authorization is valid until I provide Moving Forward Physical Therapy, P.C. with a written notice of cancellation.

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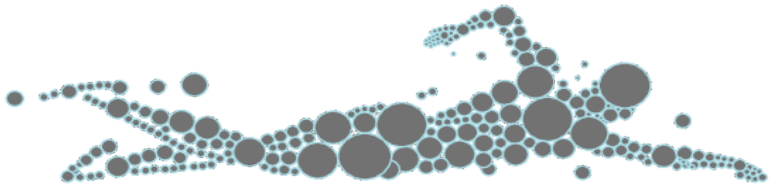

FINANCIAL POLICY

Upon referral from a physician, or other sources, Physical Therapy services are provided in this clinic by a licensed Physical Therapist or Physical Therapy Assistant. These services may be billed under a separate provider with charges that are specific to Physical Therapy.

Physical Therapists are required to conduct their own independent evaluation and establish a plan of care in order to bill for their services.

You will receive charges on your bill for a Physical Therapy evaluation and in addition any and all types of Physical Therapy treatment you have received.

We will make every attempt to pre-authorize your physical therapy services with your primary insurance company.

You will be responsible for any pre-authorization requirements for secondary or tertiary coverage as well as any third party such as auto accidents. There may be a separate co-pay charge for Physical Therapy depending upon your insurance.

Please be aware, depending on your insurance, reimbursement checks might be sent to you directly. Please endorse and remit any checks sent to you by your insurance as a form of payment for services rendered. Failure to do so will result in your account being turned over to an outside collection agency with additional surcharge fees. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. If your carrier deems services not medically necessary, you will be responsible for all non-covered charges.

Please be responsible for all payments as well as payments at the time of visit. I agree, understood and have read the above information.

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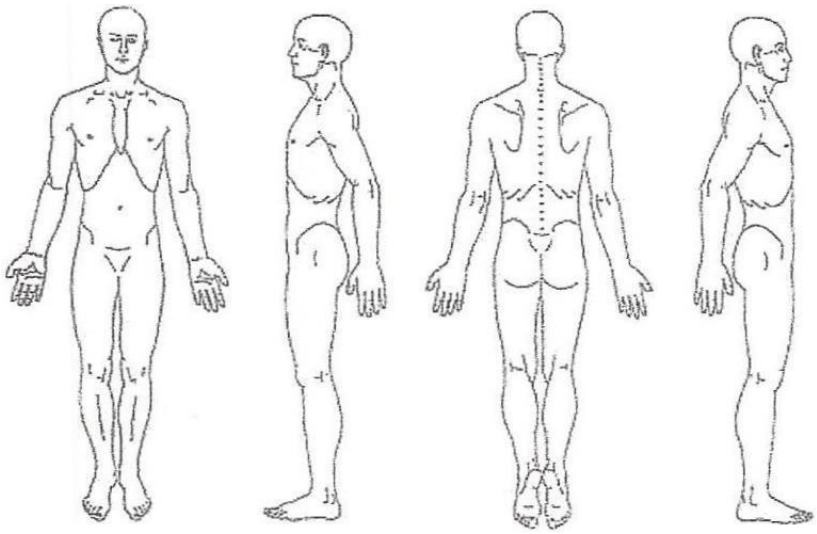
PATIENT HISTORY

Name:		Age:		Right-handed	Left-handed
Chief Complaint:					
Rate your chief complaint in order of severity from 1 to 5; 1 as the least and 5 most severe:					
Pain	Loss of Motion	Swelling	Stiffness	Loss of Function	
Date of onset of symptoms:					
How did the problem begin?					
Have you had x-rays MRIs? If so, what were the results?					



Indicate where your symptoms are on the diagram to the left.

Use the symbols below to indicate the symptoms you are experiencing:

\+ Numbness/Tingling
\# Pain
\> Other _____

Circle/check a number from 0 – 10 to indicate the severity of your pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

What makes your symptoms worse:			
What, if anything, eases your pain/symptoms:			
Are your symptoms worse in:	Morning	Afternoon	Evening
Details:			
Does your current problem disrupt your sleep?	Yes	No	Occasionally
Since the initial onset, are your symptoms:	Improving	Stable	Worse
Have you had similar occurrences? If yes, please describe:			
Allergies:			
Current Medications:			
Past Surgeries:			

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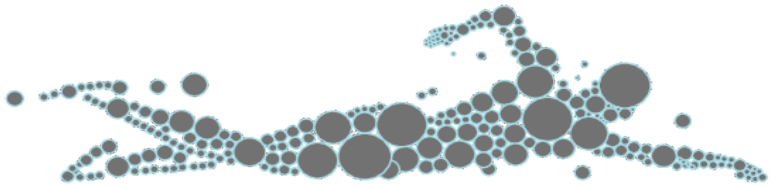

Pacemaker?	Yes	No	Pregnant?	Yes	No
Additional Illnesses? If no, leave blank. If yes, please describe.					
Have you had anesthesia where your symptoms occur?			Yes	No	
With your current complaint do you experience (check all that apply):					
Changes in bowel or bladder function			Dizziness or Vertigo		
Tingling in hands and/or feet			Nausea or Vomiting		
Changes in weight or appetite			Fever, Chills, or Sweats		
Intolerance to hot or cold			Bruising or bleeding disorders		
Skin change (rash, discoloration, etc.)			Problems with coughing or sneezing		
Changes in vision (blurred, double)			Gait disturbance		
Muscular weakness			Shortness of breath		
Changes in exercise tolerance			Headaches		
Have you or an immediate family member ever been told that you have:			**For your current condition, have you received treatment from:**		
Cancer	Yes	No	Orthopedist	PT	
Diabetes	Yes	No	Osteopath	Acupuntrist	
Osteoporosis	Yes	No	Physiatrist	LMT	
High Blood Pr.	Yes	No	Neurosurgeon	Chiropractor	
Heart Disease	Yes	No	Podiatrist	Internist	
Asthma	Yes	No	OBGYN	Other	
Current Occupation:			Working?	Yes	No
Activity Level:	Sedentary		Light	Active	Very Active
Activities you participate in:					
Do you drink alcohol?	Yes	No	Occasionally		
Do you smoke tobacco?	Yes	No	Occasionally		

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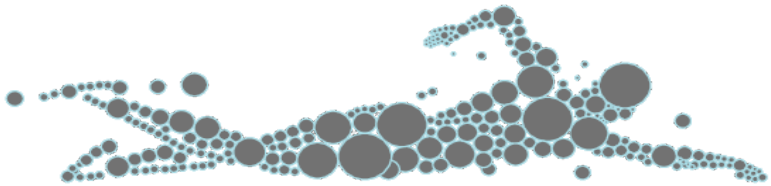

NOTICE OF PRIVACY POLICY

The privacy of your medical information is important to us. You may be aware that the US government regulators established a privacy rule through the Health Insurance Portability and Accountability Act ("HIPAA"), governing protected health information. This notice tells you about how it may be used, and about certain rights that you have. Moving Forward Physical Therapy PC is in charge of privacy matters at our facility. You can contact Dr. Vitaly Dvoskin PT, DPT with any questions or concerns you might have.

Use and disclosure of protected information: Federal law provides that we may use your medical information (protected health information) for treatment of you, without further specific notice to you, or written authorization by you; for example, we may send your referring physician a copy of your initial evaluation or a periodic progress report to let them know how your care is progressing.
Federal law provides that we may use your medical information to obtain payment for our services without further specific notice to you, or written authorization by you; for example, most insurance carriers require a copy of your documentation to pre-certify care, extend care and review specific claims for payment.
Federal law provides that we may use your medical information for healthcare operations without further notice to you, or written authorization by you; for example, our accountants may see you name, dates of treatment and procedure codes during audits of our records.
We may use or disclose your medical information without further notice to you or authorization by you when:

- required by law
- required for public health purposes;
- required by law to report child abuse;
- required by a health oversight agency for activities authorized by law, such as the Department of Health, Office of Professional Discipline or Office of Professional Medical Conduct.
- required by a coroner or medical examiner
- permitted by law for organ donor purposes
- permitted by law to a funeral director
- permitted by law to avert a serious threat to health or safety
- permitted by law and required by military authorities if you are member of the US Armed Forces

NY State law provides additional protection for information regarding HIV/AIDS. We will continue to follow NY State law with respect to such information.

We may contact you by mail or phone at your residence to remind you of appointment or to provide information about treatment alternatives. Unless you instruct us otherwise, we may leave a message for you on an answering device or with any person who answers the phone at your residence.
You can make reasonable requests, in writing, for us to use alternative methods of communicating with you in a confidential manner. Space is provided on this form below.

Other uses of disclosure of your medical information will be made only with your written authorization. You have the right to revoke any written authorization that you give.

Rights You Have: You have the right to request restrictions on certain of the uses or disclosures described above. Except as stated below, we are not required to agree to such restrictions.
You have the right to inspect and obtain copies of your medical information (a reasonable fee will be charged).
You have the right to request amendments to your medical information. Such requests must be in writing, and must state the reasons for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.
You have the right to request an accounting of any disclosures we make of our medical information, except for: disclosures we make to you or carry out treatment, payment or health care operations or as requested by your written authorization, or a permitted or required under 45 CFR 164.502, or for

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emergency or notification purposes, or for national security or intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law (or for research or public health purposes after being de-identified or limited to remove personally identifiable information) or disclosures made before January 1, 2004.

Obligations We Have: We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices.
We are required to abide by the terms of this notice as long as it is currently in effect.
We reserve the right to revise this notice and to make a new notice effective for all protected health information we maintain.
Any revised notice will be posted in our facility and copies will be available there.
If you want to complain about violations of your privacy rights, you have the right to file a complaint with the Secretary of the Department of Health and Human Services of the United States. You may also file a complaint with us directly. Complaints should be directed to

Dr. Vitaly Dvoskin, PT, DPT
Moving Forward Physical Therapy P.C.
30 East 60th Street, Suite 505
New York, NY 10022

No retaliatory action will be taken against you for any complaint that you make.

I have received a paper copy of this notice

PATIENT SIGNATURE DATE

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Good Faith Estimate for Health Care Services

Personal Information

First Name:		**Last Name:**	
Address 1:		**Address 2:**	
City/State		**Zip:**	
Home #:		**Work #:**	
Cell #:		**Fax #:**	
Date of Birth:		**SSN:**	
Email:			

Patient Diagnosis:

Primary Service and Estimated Cost:	
Secondary Services and Estimated Cost:	
Tertiary Service and Estimated Cost:	

Total Estimated Cost:

Date of Good Faith Estimate:

The following is a detailed list of expected charges for Physical Therapy Services, scheduled for [LIST DATE OF SERVICE, IF SCHEDULED]. These services and items are recurring until treatment is completed, "The estimated costs are valid for 12 months from the date of the Good Faith Estimate."