ONE STEP AHEAD PHYSICAL THERAPY
2 Healey Avenue, Plattsburgh, NY 12901 Phone: (518) 561-2225 Fax: (518) 561-2212
WWW.ONESTEPAHEADPT.COM

**Registration Form (Please Print)**

Name_____
First Middle Initial Last
Date of Birth_____Age_____Sex_____SSN_____
Permanent Address_____
City_____State_____Zip Code_____
Home Phone_____Cell Phone_____Work Phone_____Ext.____
Email Address_____ Single Married Other
Employer_____Occupation_____
Phone_____Address _____
City_____State_____Zip Code_____
Emergency Contact_____
Relationship_____ Phone_____
Referring Physician_____Family Physician_____
Is your condition a result of a work injury? Yes No Initials_____
Is your condition the result of an auto accident? Yes No Initials_____

**Health Insurance**

Primary Health Insurance _____Co-Pay_____
Patient ID Number _____Group Number_____
Name of Insured _____ Date of Birth of Insured _____
Secondary Health Insurance _____Co-Pay_____
Patient ID Number _____Group Number_____
Name of Insured_____Date of Birth of Insured _____

**Medicare Waiver of Liability**

Medicare will limit (cap) services per year in a private setting only for Physical Therapy, Occupational Therapy, and Speech Language Pathology combined. In the event of a denial, you the patient are responsible to pay for the services.
Initials_____

**Assignment and Release: I authorize payment of benefits be made directly to this healthcare provider and I understand that I am responsible for charges not covered by this assignment. I also authorize the release of any information requested to process the claim. If I cannot settle my account at the time of visit, I understand special arrangements need to be made. I understand that if my account should become delinquent, I will be responsible for all reasonable collection costs and attorney fees. *I understand that if I cannot attend a scheduled appointment and do not call to cancel that appointment at least 24 hours in advance that I may be charged a no-show fee of $45.00 and as well as a $10 fee if I do not pay my co pay at the time of my visit.* I also understand that this no-show fee will not be billed to or covered by my insurance and I am responsible.**

_____

Signature of Patient or Patient Representative/Guardian Date

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**Personal Health History**

**Please check any of the following that apply to you (Past or Present):**

- □ Cancer
  If yes, what kind and when _____
- □ Depression
- □ Allergies
  Please list_____
- □ Diabetes
- □ Thyroid Problems
- □ Anemia
- □ Hearing Loss
- □ Visual Problems
- □ Kidney Disease
- □ Rheumatoid Arthritis
- □ Other type of Arthritis
- □ Pacemaker
- □ Heart Disease/Condition
- □ Broken bones/fractures
  Please list_____
- □ Bladder Incontinence
- □ Bowel Incontinence
- □ Low Blood Pressure
- □ High Blood Pressure
- □ Multiple Sclerosis
- □ Hepatitis
- □ Seizures
- □ Stroke
- □ Osteoporosis
- □ Blood Clots
- □ HIV
- □ Pregnancy (Past or Present)
- □ Emphysema/Bronchitis
- □ Asthma

Do you smoke? Yes No If yes, how many cigarettes per day?_____

Age_____Weight _____Height_____

Medications (Prescription and Over-the-counter)_____

_____

Surgeries_____

_____

Diagnostic Tests (Please List Dates and Results) _____

_____

Reason for Referral to Physical Therapy_____

_____

Previous Treatment for Present Condition_____

_____

**Informed Consent: I hereby desire to engage in, voluntarily or under the orders of a physician, evaluation and treatment at One Step Ahead Physical Therapy, PC.**

_____

Signature of Patient or Patient Representative/Guardian Date

# ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I understand that One Step Ahead Physical Therapy, PC (referred to below as "the clinic") will use and disclose **health information** about me in the course of providing physical therapy care to me.

I understand that my **health information** may include information both created and received by the clinic, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar health-related information.

I understand that the clinic is permitted to **use and disclose** my health information in order to:

- Make decisions about and plan for my care and treatment.
- Refer to/or consult and coordinate with other health care providers in the course of my treatment.
- Determine my eligibility for health plan or insurance coverage; submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care.
- Perform various office, administrative, and business functions that support the clinic's ability to provide me with appropriate care and arrange for payment.

I understand that the Notice of Privacy Practices may be revised and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request, and that a copy or a summary of the most current version of the clinic's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that the Notice of Privacy Practices describes how I can exercise my right to ask that some or all of my health information not be used or disclosed, and I understand that the clinic is not required by law to agree to such requests.

**By signing below, I agree that I have received or been offered a copy of this clinic's Notice of Privacy Practices.**

_____

Patient Name (Please Print)

_____

Signature of Patient or Patient Representative/Guardian Date

Description of Representative's Authority_____

.....

**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____Individual refused to sign

_____Communication barriers prohibited obtaining the acknowledgment

_____An emergency situation prevented us from obtaining acknowledgement

_____Other (Please specify)_____