True Way Physical Therapy, P.C. PATIENT REGISTRATION FORM

388 Westchester Ave St 1, Port Chester, NY 10573 Tel: 914-481-8777 Fax: 914-481-8780

PERSONAL INFORMATION

PATIENT		PRIMARY SUBSCRIBER	
Name		Name*	
Address		Address*	
Telephone: H/C:		Telephone*H/C:	
Telephone Work:		Telephone* Work:	
Occupation		Occupation*	
Employer		Employer*	
Birth Date	Sex M F	Birth Date	Sex M F
SS#	Marital S M D W	SS#	Marital S M D W
Referring Provider			*If Different
OTHER: Who may we thank for referring you to us:			
Emergency Information		Pharmacy Information	
Name		Name	
Telephone		Telephone	
Address		Allergies	
Attorney (if applicable)			
Name/Telephone/Address:			

INSURANCE INFORMATION

Primary	Subscriber*	Relationship	ID# Group#
Second/Third		Relationship	ID# Group#
Workman's Compensation		No Fault	
WCB#	Carrier Case#	Policy Holder	
Insurance Carrier		Policy #	Claim#
Carrier Address:		Insurance Carrier/Address:	
Contact Person/Adjuster	Telephone	Contact Person	Telephone
Date of Injury	Time	Date of Injury	Time
Place of injury (address)		Place of injury (address)	
IME (Independent Medical Examination) Date:		IME (Independent Medical Examination)Date:	

Patient Release: I authorize the release of medical information to any insurance company, adjuster, or attorney involved in this case. I also authorize True Way Physical Therapy P.C. and its staff to call my home and leave messages regarding appointments with my spouse/relative and or answering machine. Furthermore, I authorize the use of facsimile/e-mail/internet and electronic transmission of my personal health information for the purpose of treatment, payment, and health care operations. I acknowledge that interest or fee, at the provider's current rate , may be charged on balances owing to the provider that are past due. I permit a copy of this release to be used in place of the original.

Signature:____ Date ___________/______ /20______

(Signature of insured or authorized person, patient or parent if minor)

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PATIENT MEDICAL HISTORY

Name: (PRINTED)______________________________ Referring Physician ______________________________

Primary Care Physician: ______________________________ Date of 1st doctor visit for this injury/episode ______________________________

Is an attorney involved in this case? YES NO

Have you ever had surgery for this injury? YES NO Number of surgeries: 1 2 3 4 5

Type of surgery ______________________________ Date ______________________________

Please enter you: Occupation ______________________________ HEIGHT ______________ WEIGHT ______________ AGE ________ Sex M F Activities & hours involved in Occupation if applicable (sitting/standing/bending/lifting/walking): ______________________________ N/A: ______________________________

Are you currently taking any prescription or non-prescription medications? YES NO

List any medications currently being taken:

	YES	NO		YES	NO
Chiropractor	___	___	EMG/NCV	___	___
Neurologist	___	___	Myelogram	___	___
Orthopedist	___	___	Emergency Room Care	___	___
General Practitioner	___	___	CT Scan	___	___
Occupational Therapy	___	___	MRI	___	___
Physical Therapy	___	___	X-Rays	___	___

OTHER ______________________________ If YES (X-Rays/MRI/CT Scan, etc) date & results:______________________________

Do you now have or have you ever had ANY of the following?

	YES	NO		YES	NO
Asthma, bronchitis, or emphysema	___	___	Severe/frequent headaches	___	___
Shortness of breath/chest pain	___	___	Vision/hearing difficulties	___	___
Coronary heart disease or angina	___	___	Dizziness or Fainting	___	___
Heart attack or surgery	___	___	Weight loss/Energy Loss	___	___
Do you have a pacemaker	___	___	Hernia	___	___
High blood pressure	___	___	Allergies	___	___
Stroke/TIA	___	___	Any joint/metal implants	___	___
Blood clot/emboli	___	___	Joint Replacement Shoulder	___	___
Epilepsy/seizures	___	___	injury/surgery Elbow/hand	___	___
Anemia	___	___	injury/surgery Neck/back	___	___
Infectious disease	___	___	injury/surgery Knee	___	___
Diabetes	___	___	injury/surgery Leg/ankle	___	___
Cancer or chemotherapy/radiation	___	___	injury/surgery Are you	___	___
Arthritis/swollen joints Osteoporosis	___	___	pregnant	___	___
Sleeping problems/difficulties	___	___	Do you smoke/drink alcohol	___	___
Anxiety	___	___	Difficulty/Frequent urinating	___	___
Alzheimer's	___	___	Depression	___	___
Thyroid Condition	___	___	Dementia	___	___
		___	Night Pain	___	___

List any other information that would assist us in your care

____

Are you aware of your diagnosis? YES NO

Patient or Responsible Party Signature: ______________________________

Date: ______________________________

I have reviewed this information with the patient

Signature: ______________________________

Dr. Mon Caddauan, PT, DPT, OCS, Cert MDT, NDT Trained

Board Certified Orthopedic Clinical Specialist

Doctor of Physical Therapy

Date: ______________________________

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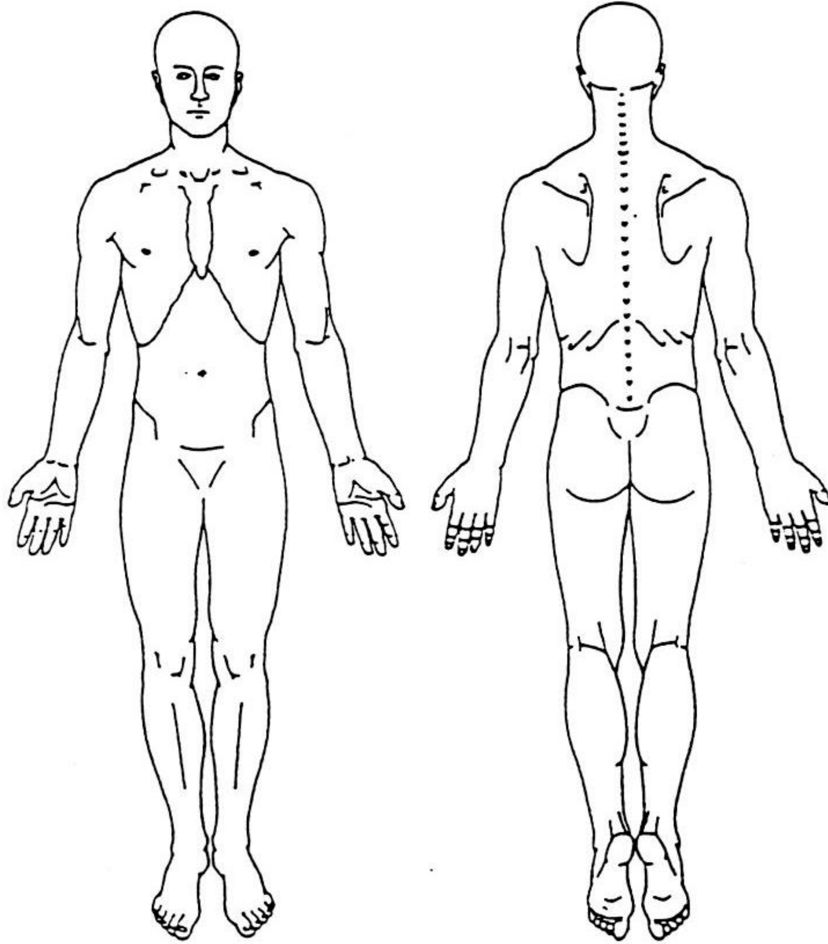
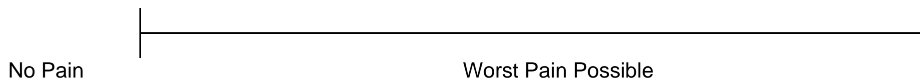
Body Diagram

Instructions:

On the body diagram below, please indicate where your pain is located at the present time. Please do not indicate areas of pain that are not related to your present injury or condition,



Indicate on the line below how you would describe your present pain by placing a mark on the line between the two extremes of experiencing no pain at all and experiencing the worst pain you have ever felt.



No Pain Worst Pain Possible

Shade in the areas on the diagram that correspond to your pain or symptoms (circle all that apply)

Sharp Dull Aching Burning Tightness

Numbness Tingling

Localized Radiating Constant Intermittent

Patient: ____ Date: ________________________

TRUE WAY PHYSICAL THERAPY, PC

☒388 WESTCHESTER AVE, SUITE 1N
PORT CHESTER, NY 10573
PHONE: (914) 481-8777
FAX: (914) 481-8780

☐ 10 CHESTER AVE, SUITE 2
WHITE PLAINS, NY 10606
PHONE: (914) 725-4111
FAX: (914) 725-5111

MYTRUEWAYPT@OPTONLINE.NET
TRUEWAYPT.COM

Notice of Privacy Practices Summary

This notice is a summary of how your protected health information is used and disclosed and how you can obtain access to this information. Please see the front desk a full copy of out Notice of privacy practices.

Use and Disclosures of Health Information

We use health information about you for treatment, to obtain payment for treatment, for administration purposes, and to evaluate the quality of care that you receive.

We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information you can disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and in each examination room. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Your Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- Obtain a proper copy of the notice of privacy practices upon request
- Inspect and obtain a copy of your health record of your health record as provided for in 45 CFR 164.524
- Amend your health record as provided in 45 CFR 164.528
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information exempt to the extent that action has already been taken

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. department of health and human services. The person listed below can provide you with the appropriate address upon request.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If you have any questions or complaints, please contact: Dr. Mon Caddauan 388 Westchester Ave Suite 2A, Port Scarsdale NY 10573
914-481-8777

<u>Written Acknowledgement</u>

I acknowledge that I have reviewed **the Notice of Privacy practices** which provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions I request

X ______________________ X ______________________

Signature of Patient or Legal Represenative Date