BODY HARMONY PHYSICAL THERAPY, PLLC

PLEASE PRINT CLEARLY
New Patient Intake Form **Date:** _____

Patient Information
Name: _____
Date of Birth: _____
Sex: M F _____ Married _____ Single: _____
Contact Phone Number: _____
Email Address: _____

Social Security Number: _____

Address (H):_____
City, State, Zip Code _____

Occupation: _____
Address (Work):_____
Employer:_____
Work Phone Number: _____

Emergency Contact: _____ Phone Number: _____
Patient Relationship with Emergency Contact:_____

Referring Practitioner: _____
Address: _____
Phone Number: _____

Have a written Prescription: _____
If no, has patient been informed to get one prior to 1st Visit? _____

Insurance Information
Primary Insurance: _____ ID/Subscriber/Policy# _____
Secondary Insurance: _____ ID/Subscriber/Policy# _____

If you are not the primary insured please supply:
Name of the Primary Insured: _____Date of Birth:_____

Payment Information (circle one)
MC Visa Discover Amex
Name on Credit Card: _____
Credit Card Number: _____
Expiration Date: _____Security Code:_____
Billing Address: _____
Billing Phone Number: _____

Other MD's/Practitioners (please list specialty of MD) you are currently seeing:
_____
_____
_____
_____

BODY HARMONY PHYSICAL THERAPY, PLLC

NOTICE OF PATIENT INFORMATION PRACTICES FOR HIPAA COMPLIANCE TO GIVE TO PATIENTS ALONG WITH SIGNATURE SHEET

NOTICE OF PATIENT INFORMATION PRACTICE

This notice describes how medical information about you may be used or disclosed by this Practice and how you can get access to information. Please review it carefully.
LEGAL DUTY This practice is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described here.

USES AND DISCLOSURES OF HEALTH INFORMATION This practice uses your health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities and evaluating the quality of care that we provide. We may also use or disclose your personal health information for public health purposes, audits, emergencies and when required by law.
In any other situation, our policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.
We may change our policy at any time. When changes are made a new Notice of Information Practices will be posted in our office and you will receive a new written notice as well.

PATIENT'S INDIVIDUAL RIGHTS You have the right to review or obtain a copy of your personal health information at any times. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.
You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. We will consider all such requests on a case by case basis, but the company is not legally required to accept them.

CONCERNS AND COMPLAINTS
If you are concerned that we may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact the Privacy Officer at the address listed below. You may also send a written complaint to the US Department of Health and Human Services.

BODY HARMONY PHYSICAL THERAPY, PLLC
233 BROADWAY, SUITE 2060, New York, NY 10279

BODY HARMONY PHYSICAL THERAPY, PLLC

PATIENT INFORMATION CONSENT/ACKNOWLEDGEMENT FORM FOR HIPAA COMPLIANCE

I have read and understand the attached **Notice of Patient Information Practices**. I understand that the company may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the company. I also understand that this practice will consider requests for restrictions on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in the Company's **Notice of Patient Information Practices**. In doing so, I hereby release Wall Street Wellness & Physical Therapy, PLLC from any and all legal liability that may arise from the release of such information. I agree that a copy of this authorization may be used in place of the original.

I understand that I retain the right to revoke this consent by notifying the practice in writing at any time except for that action which has already been taken. It shall be effective only long enough to answer the purpose of which it is given and no further confidential information will be released without the execution of an additional written authorization.

I have been given an opportunity to read and ask questions about the Notice.
Please circle one:
May we leave a message regarding an upcoming appointment on:

Answering machine at home?	YES or NO	Office voice mail?	YES or NO
With another person?	YES or NO	Send through mail?	YES or NO
Send through email?	YES or NO		

May we leave other medical information on:

Answering machine at home?	YES or NO	Office voice mail?	YES or NO
With another person?	YES or NO	Send through mail?	YES or NO
Send through email?	YES or NO		

Person(s) authorized to discuss above?
Name: _____ Relationship: _____

Patient and Parent/Guardian's Printed Name if Patient is under 18

_____ _____
Signature Date

_____ _____
Signature Date

BODY HARMONY PHYSICAL THERAPY, PLLC

CONDITIONS & CONSENT FOR CARE AND TREATMENT

PLEASE INITIAL EACH STATEMENT

Informed consent for treatment:
The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition. _____
Potential risks: I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist. _____
Potential benefits: I may experience an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me. _____

Cooperation with treatment:
In order for physical therapy treatment to be effective, I must come to my scheduled appointments, except in the case of extenuating circumstances. I understand and agree to cooperate with and perform the home physical therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss my concerns with my therapist.
_____

No warranty: I understand that there are no guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will outline and discuss goals of physical therapy treatment for my condition and will discuss treatment options with me. _____

Release of medical records:
- I understand that as part of my healthcare, **Body Harmony Physical Therapy, PLLC,** will maintain my health records. This includes my health history, symptoms, examination, test results, diagnosis, treatment, and any plans for future treatment. _____
- I understand that this information serves as a basis for planning my care and treatment and a source of information for applying my diagnosis and treatment to my bill. _____
- I understand that this information serves as a means of communication among the many health professionals who contribute to my care. _____
- I authorize **Body Harmony Physical Therapy, PLLC** to release all my medical records to physician(s) and other health care professionals involved, and to my insurance company, if applicable. _____
- I allow fax transmittals of my medical records if necessary. _____
- I understand that this information serves as a means by which a third party payer can verify that services billed were actually provided. _____
- I understand that my therapist may communicate with other health care providers involved in my care through email communication. _____

I have read the above information and fully understand and consent to physical therapy evaluation and treatment.

_____ _____
Patient Name Date

_____
Patient or guardian signature

BODY HARMONY PHYSICAL THERAPY, PLLC

INFORMED CONSENT FOR ASSESSMENT AND/OR TREATMENT OF THE PELVIC FLOOR.

I understand that if I am referred to physical therapy for pelvic floor dysfunction, it may be beneficial for my therapist to perform a *muscle assessment and/or treatment of the pelvic floor*, initially and periodically to assess muscle strength, length, range of motion, and scar mobility. Palpation of these muscles is most direct and accessible if done via the vagina and/or rectum.

Pelvic floor dysfunctions' include, but not limited to, pelvic pain syndromes, urinary incontinence, fecal incontinence, dyspareunia or pain with intercourse, pain from an episiotomy or scarring, vulvodynia, vestibulitis or other similar complications. Restrictions in this area may also be contributing to symptoms in other areas of your body.

Internal examination of the pelvic floor muscles is consistent with the physical therapy practice. It complies with national physical therapy policies requiring the performance of test and measurements of neuromuscular function as an aid to the evaluation and treatment of a specific medical condition.

- This statement was adopted by the executive committee of the Section on Obstetrics and Gynecology of the American Physical Therapy Association.
- San Antonio, Texas, February 1993

Evaluation and treatment of my condition may include, without limitation, observation, use of vaginal cones/weights/dilators, vaginal or rectal sensors for biofeedback, and/or electrical stimulation, ultrasound, education, exercise, and several manual techniques including massage, myofascial release, joint, nerve, and soft tissue mobilization. The therapist will explain all these treatment procedures to me and I may choose to not participate with all or part of the treatment plan. I understand that no guarantees have been or can be provided to me regarding the success of therapy.
I understand that the benefits of the vaginal/rectal assessment and treatment will be explained to me. I understand that if I am uncomfortable with the assessment or treatment procedures AT ANY TIME, I will inform my therapist and the procedure will be discontinued and alternatives will be discussed with me.

I have read and understand fully the above procedure(s) being performed by the physical therapist(s) at BODY HARMONY PHYSICAL THERAPY, PLLC.
Any questions, which may have occurred to me, have been answered to my satisfaction. I understand the risks, benefits and alternatives of the treatment.
Based on the information I have received from the therapist, I voluntarily agree to standard assessment and muscular treatment techniques of the pelvic/perineal area.

_____ _____
Patient's Signature Date

If you are pregnant, have an infection of any kind, have vaginal dryness, are less than 6 weeks post partum or post surgery, have severe pelvic pain, sensitivity to KY jelly, vaginal creams or latex, please inform the therapist prior to the pelvic floor assessment.