New York BONE and JOINT SPECIALISTS

Leon E. Popovitz, MD
Orthopedic Surgeon & Sports Medicine

Patient Name: _____

Date	Phone/Office Communication	Initials

New York BONE and JOINT SPECIALISTS

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Orthopedic Surgeon & Sports Medicine

Patient Name: _____ **Date:** _____

REFERRAL INFORMATION:

How did you first hear about New York Bone & Joint Specialists?

- ☐ I am a **Past Patient**
- ☐ Referred by a **Doctor** (*Who*?)_____
- ☐ Referred by a **Friend** (*Who?*) _____
- ☐ Referred by an **Embassy** (*Which?*)_____
- ☐ Referred by an **Insurance**
- ☐ **Other**_____
- ☐ Received a **Postcard**
- ☐ **Internet**:
  - ☐ **Google Search**
  - ☐ **ZocDoc**
  - ☐ **Yelp**
  - ☐ **Facebook**
  - ☐ **Other**_____

PATIENT MEDICAL HISTORY:

Age _____ **Height** _____ **Weight** _____ **Dominant Hand:** ☐Right ☐Left

Chief Complaint: **Knee Pain:** ☐Right ☐Left
Shoulder Pain: ☐Right ☐Left
Other:_____

How and When did the Injury occur? (*Briefly explain)*:_____

_____

How long have you had symptoms?_____ **Where is your pain located?**_____

When do you have pain?_____ **Do you have pain at night?** _____

What makes your pain worse? _____

What makes your pain better_____

Describe your pain (*check any that apply*): ☐sharp ☐burning ☐shooting ☐achy ☐knife-like ☐twisting ☐pressure ☐toothache ☐deep ☐heavy ☐gnawing ☐throbbing ☐dull ☐pulsating

 Patient Name _____

Using the #'s below, how severe is your pain? _____

0 (no pain)
1-2 (tolerate without medication)
3-4 (tell someone about my pain, take aspirin or Motrin)
5-6 (mild narcotic, ex. Tylenol #3)
7-8 (go to the emergency room, take strong narcotic)
9-10 (admission to the hospital for pain control)

PERSONAL MEDICAL HISTORY:

Please check any that apply: ☐ hypertension ☐ diabetes mellitus ☐ cancer ☐ peptic ulcer ☐gastritis
☐ reflux ☐ angina ☐ arrhythmia ☐ seizures ☐ HIV ☐ hepatitis
☐ Other _____

Do you have a history of? ☐ Ulcer/gastritis ☐ Kidney disease ☐ Bleeding disorder

Please list any medications you are taking: _____

_____

_____

Medical Allergies: _____

Are you allergic to: ☐ Tape ☐ Iodine ☐ Latex

Are you taking any of the following? ☐ Blood thinners ☐ Anti-depressive medication

Past Surgeries: _____

_____

_____

Have you had previous surgeries on the affected joint? *If yes, what kind:* _____

_____

_____

Family Medical History (*parents, siblings, children orgrandparents*): _____

_____

_____

Patient Name _____

SOCIAL HISTORY:

Type of job: _____

Drug, alcohol or tobacco use: _____

Who do you live with? _____

Hobbies: _____

REVIEW OF SYSTEMS *(Please check any that apply)* **:**

Constitutional: ☐weight change, ☐weakness, ☐fatigue, ☐fever

Eyes: ☐glasses, ☐pain, ☐tearing, ☐double vision

Ears, Nose, Mouth & hroat: ☐tinnitus, ☐dizziness, ☐pain, ☐sinus, ☐colds, ☐sore throat

Cardiovascular: ☐high blood pressure, ☐rheumatic fever, ☐murmurs, ☐shortness of breath, ☐chest pain, ☐palpitations

Respiratory: ☐cough, ☐sputum, ☐coughing up blood, ☐wheezing, ☐asthma, ☐bronchitis, ☐chest pain

Gastrointestinal: ☐difficulty swallowing, ☐heartburn, ☐vomiting, ☐diarrhea, ☐indigestion, ☐pain, ☐blood, ☐stool changes

Genitourinary: ☐pain with urination, ☐urinating at night, ☐blood in urine, ☐urgency, ☐hesitancy, ☐incontinence

Skin: ☐rash, ☐lumps, ☐itching, ☐dryness, ☐color change, ☐hair changes, ☐nail changes

Neurological: ☐fainting, ☐blackouts, ☐seizures, ☐paralysis, ☐memory loss

Psychological: ☐nervousness, ☐tension, ☐mood changes, ☐depression, anxiety

Endocrine: ☐heat or cold intolerance, ☐sweating, ☐thirst, ☐hunger, ☐change in urination

Hematology/Lymphatic: ☐bruising, ☐bleeding, ☐ transfusion reactions

Allergies/Immunological: ☐drug, product or other allergies

Reproductive: ☐sexual dysfunction, ☐pregnancy

Name of Primary Care Physician: _____ **Phone:** _____ **Fax:** _____

Comments: _____

Patient's Signature: _____ **Date** _____

PATIENT INFORMATION FORM:

First Name:	**Last Name:**	**Middle Initial:**	**Suffix:**	**Date:**
Address:				
City:	**State:**	**Zip Code:**	**Social Security #:**	**Date of Birth:**
E-mail Address:	**Cell Phone:**		**Home Phone:**	**Work Phone:**
Occupation:	**Employer:**		**Company Address:**	
Emergency Contact *(First & Last Name)*:			**Emergency Contact Phone:**	**Emergency Contact Relationship:**
Referring Physician:	**Referring Physician Phone:**		**Referring Physician Address:**	

INSURANCE INFORMATION:

Guarantor Name:	**Date of Birth:**	**Social Security #:**	☐ **Self/** ☐**Other(Relation:_____)**
Insurance Name:		**Insurance Phone:**	
Insurance Address:			
Insurance Policy #:		**Insurance Group #:**	
Signature of Insured:			**Date:**

SECONDARY INSURANCE INFORMATION:

Guarantor Name:	**Date of Birth:**	**Social Security #:**	☐ **Self/** ☐**Other(Relation:_____)**
Insurance Name:		**Insurance Phone:**	
Insurance Address:			
Insurance Policy #:		**Insurance Group #:**	
Signature of Insured:			**Date:**

ASSIGNMENT OF BENEFITS & ADVANCE PATIENT NOTIFICATION FORM FOR ALL SERVICES:

Signing this form helps ensure payment and acknowledges notification of your rights and coverage.

Your health care services are provided by Doctors, Physician Assistants, Acupuncturists and Physical Therapists of New York Bone & Joint Specialists. The health care providers are licensed in the State of New York and/or New Jersey.

I hereby assign to New York Bone and Joint Specialists, PLLC my right to receive reimbursement for medically necessary health care services, including surgical services, provided to me and/or to any beneficiary under my health benefits policy. I hereby authorize and direct my insurance carrier to make all such payments directly to New York Bone and Joint Specialists, PLLC for all claims. Such payments should be forwarded by my insurance carrier directly to New York Bone and Joint Specialists, PLLC, at the address below, in the form of a check payable to New York Bone and Joint Specialists, PLLC or, in alternative, a check payable to New York Bone and Joint Specialists, PLLC and me, as joint payees. I understand that I have the right, upon request, to be provided the amount, or estimated amount, I will be billed. Please note that such estimates cannot account for unforeseen medical circumstances that may arise while the services are performed. Please further note that such estimates are as of the date of provision of the information to you and may be subject to change. I understand and agree that, if the check from the insurance company is made payable to New York Bone and Joint Specialists, PLLC and me as joint payees, that I promptly will endorse and deliver the check to New York Bone and Joint Specialists, PLLC or will write a personal check for the full payment that is due within (1) one week of receiving payment. I am aware that my health care provider will accept my insurance plan's out-of-network benefits as assigned since the provider does not participate in the plan. I will provide the entire Explanation of Benefits from my insurance carrier relating to the services provided.

Administrative office address:

New York Bone and Joint Specialists, PLLC

155 East 55th St Ste 5D
New York, NY 10022

REGARDING PAYMENT: If you do not have medical insurance with out-of-network benefits, payment in full is expected and due at the time of service. We accept cash, checks, Visa, Master-card & Discover.

OUT-OF-NETWORK BENEFITS, DECUCTIBLE & CO-INSURANCE: By your signature below, you acknowledge that you have read and understand this notice and choose to undergo and receive out-of-network services voluntarily, and to pay for these items and services on your own initiative and free will. Any medical charges on your account are your responsibility, whether your insurance company pays or not. As courtesy, we file claims with your insurance. We will attempt to collect from your insurance company. Ultimately, your insurance policy is a contract between you and your insurance company and we are not a party to that contract. If your insurance company does not pay your account within 90 days, the balance becomes your responsibility.

This document does not waive or abrogate any financial responsibility you may have for the professional services and items provided to you, including as required by you insurer. Any deductible, co-insurance or other amount that your insurance company or benefit program considers to be your responsibility will be paid directly by you to us. You will be asked to pay the deductible and/or co-insurance at the time of the service, or at our option by invoice following service. If you are unable to demonstrate your co-insurance amount, you will be asked to pay 20% of your bill. Over-payments and underpayments may occur in collecting from you and your insurance company. We will collect or refund amounts more than three dollars on all accounts. Refunds will be sent out at least once annually.

USUAL AND CUSTOMARY RATES: Our practice is committed to providing the best, affordable treatment for our patients. Some insurance companies arbitrarily determine usual and customary rates for medical charges, which do not take into consideration our costs and charges, and may not pay charges above what they consider "usual and customary." Any charges that your insurance company does not cover are your responsibility.

ASSIGNMENT OF BENEFITS: You hereby designate, authorize, and convey to NEW YORK BONE AND JOINT SPECIALISTS, PLLC and its physicians ("Provider") to the fullest extent permissible under law and regulation and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as your authorized representative in your place and stead in connection with any claim, right, or cause in action that you may have under such insurance policy and/or benefit plan, including but not limited to with respect to internal appeals or litigation; and (2) the right and ability to act as your authorized representative in your place and stead to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as your authorized representative with respect to a benefit plan governed by the provisions of the Employee Retirement Income Security Act of 1974 ("ERISA"), as provided in 29 C.F.R. §2560.503-1(b)(4)), with respect to any health care expense incurred as a result of the services and items you received from Provider and, to the extent permissible under the law, to claim on your behalf such benefits, claims, or reimbursement, and any other applicable remedy, including fines or injunctive relief. Through this form, you are assigning to Provider all legal rights, claims or remedies you may have under ERISA or otherwise with respect to your health insurance policy relating to the health care services and items you have received from Provider, including any claims for benefits, for breach of fiduciary duty or other claims available under law against your insurer or claims administrator. By signing below, you understand that Provider is not assuming any obligation or duty to assert such rights and you agree to release any claim you might have relating to Provider's exercise of such rights or the decision not to exercise such rights.

My signature, below, acknowledges my accepted information above and confirms my voluntary choice to obtain services from this provider at New York Bone and Joint Specialists, PLLC. I understand that I am responsible for payment for all services rendered, and I agree to pay all charges denied or not covered by my insurance carrier. This assignment and authorization in no way releases me from this responsibility and imposes no obligation on New York Bone and Joint Specialists, PLLC, to collect money upon my behalf.

I have read and understand and agree to the above. A photocopy of this agreement shall be considered as effective and valid as the original.

_____	_____	_____
Sign Name Here	**Print Name Here**	**Date**

_____	_____
Patient Name if Signing as Legal Representative	**Type of Representative**

HIPAA Omnibus Notice of Privacy Practices

Revised 2013 *Effective as of September 24, 2013*

New York Bone and Joint Specialists / All Sports Physical Therapy

Upper East Side Office:
130 E 67th St
New York, NY 10065

Midtown West Office:
67 W 55th St Ste 205
New York, NY 10019

Grand Central Office:
370 Lexington Ave Ste 614
New York, NY 10017

Upper East Side Office:
903 Lexington Ave
New York, NY 10065

Phone: (212) 759 - 4553 **www.nyboneandjoint.com** **info@nyboneandjoint.com**

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

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your "Protected Health Information" (PHI) to carry out treatment, payment or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. PHI is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.
This Notice is provided to you as a requirement of HIPAA. There are several other privacy laws that also apply to HIV-related information, family planning information, mental health information, psychotherapy notes, and substance abuse information. These laws have not been superseded, and the disclosure of such information is specifically subject to more strict privacy standards and most uses and disclosures require express authorization from you.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:
The following describes the ways we may use and disclose your PHI. Except for the purposes described below, we will use and disclose PHI only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.
For Treatment - We may use and disclose PHI for your treatment and to provide you with treatment-related health care services. For example, we may disclose PHI to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.
For Payment - We may use and disclose PHI so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.
For Health Care Operations - We may use and disclose PHI for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the orthopedic or physical therapy care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operationactivities.
Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services - We may use and disclose PHI to contact you to remind you that you have an appointment with us. We also may use and disclose PHI to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

WE MAY ALSO USE AND DISCLOSE PHI IN THE FOLLOWING CIRCUMSTANCES:
Required by Law - We may use or disclose your PHI if law or regulations requires the use or disclosure.
Public Health - We may disclose your PHI to a public health authority who is permitted by law to collect or receive the information. For example, the disclosure may be necessary to prevent or control disease, injury or disability; report births and deaths; or report reactions to medications or problems with medical products.
Communicable Diseases - We may disclose your PHI, if authorized by law, to a person who might have been exposed to a communicable disease or might otherwise be at risk of contracting or spreading the disease or condition.
Health Oversight - We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. These health oversight agencies might include government agencies that oversee the health care system, government benefit programs, or other regulatory programs.
Food and Drug Administration - We may disclose your PHI to a person or company required by the Food and Drug Administration to report adverse events; track products, enable product recalls; make repairs or replacements; or conduct post-marketing reviews.
Legal Proceedings - We may disclose PHI during any judicial or administrative proceeding, in response to a court order or administrative tribunal (if such disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.
Law Enforcement - We may disclose PHI for law enforcement purposes, including information requests for identification and location; and circumstances pertaining to victims of a crime.
Coroners, Funeral Directors, and Organ Donations - We may disclose PHI to coroners or medical examiners for identification to determine the cause of death or for the performance of other duties authorized by law. We may also disclose PHI to funeral directors as authorized by law. PHI may be used and disclosed for cadaver organ, eye or tissue donations.
Research - We may disclose PHI to researchers when authorized by law, for example, if their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.
Threat to Health or Safety - Under applicable Federal and State laws, we may disclose your PHI to law enforcement or another health care professional if we believe in good faith that its use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.
Military Activity and National Security - When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel for activities believed necessary by appropriate military command authorities to ensure the proper execution of the military mission, including determination of fitness for duty; or to a foreign military authority if you are a member of that foreign military service. We may also disclose your PHI, under specified conditions, to authorized Federal officials for conducting national security and intelligence activities including protective services to the President or others.
Workers' Compensation - We may disclose your PHI to comply with workers' compensation laws and similar government programs.
Inmates - We may use or disclose your PHI, under certain circumstances, if you are an inmate of a correctional facility.
Parental Access - State laws concerning minors permit or require certain disclosure of PHI to parents, guardians, and persons acting in a similar legal status. We will act consistently with the laws of this State (or, if you are treated by us in another state, the laws of that state) and will make disclosures following such laws.

Business Associates - We may disclose PHI to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.
Data Breach Notification Purposes - We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your PHI.

USES & DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT OUT:
Individuals Involved in Your Care or Payment for Your Care - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care., If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.
Disaster Relief - We may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.
Fundraising - In the event you are contacted for fundraising purposes, you have the right to opt out of such fundraising communications with each solicitation.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES:
The following uses and disclosures of your PHI will be made only with your written authorization:

1. Uses and disclosures of PHI for marketing purposes;
2. Disclosures that constitute a sale of your PHI.

Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose PHI under the authorization. But any disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:
You have the following rights regarding PHI we have about you:
Right to Inspect and Copy - You have a right to inspect and copy PHI that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this PHI, you must make your request, in writing, to: ***NY Bone & Joint Specialists/ All Sports Physical Therapy; Attn: HIPAA Privacy Officer; 155 E 55th St Ste 5D; New York, NY 10022.*** We have up to 30 days to make your PHI available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.
Right to an Electronic Copy of Electronic Medical Records - If your PHI is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your PHI in the form or format you request, if it is readily producible in such form or format. If the PHI is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.
Right to Get Notice of a Breach - You have the right to be notified upon a breach of any of your unsecured PHI.
Right to Amend - If you feel that PHI we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to: ***NY Bone & Joint Specialists/ All Sports Physical Therapy; Attn: HIPAA Privacy Officer; 155 E 55th St Ste 5D; New York, NY 10022.***
Right to an Accounting of Disclosures - You have the right to request a list of certain disclosures we made of PHI for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to: ***NY Bone & Joint Specialists/ All Sports Physical Therapy; Attn: HIPAA Privacy Officer; 155 E 55th St Ste 5D; New York, NY 10022.***
Right to Request Restrictions - You have the right to request a restriction or limitation on the PHI we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the PHI we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to: ***NY Bone & Joint Specialists/ All Sports Physical Therapy; Attn: HIPAA Privacy Officer; 155 E 55th St Ste 5D ; New York, NY 10022.*** We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your PHI to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.
Out-of-Pocket-Payments - If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your PHI with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.
Right to Request Confidential Communications - You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to: ***NY Bone & Joint Specialists/ All Sports Physical Therapy HIPAA Privacy Officer; 155 E 55th St Ste 5D; New York, NY 10022.***Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.
Right to a Paper Copy of This Notice - You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, **www.nyboneandjoint.com**. To obtain a paper copy of this notice, please ask the front desk at any of our locations.

CHANGES TO THIS NOTICE:
We reserve the right to change this notice and make the new notice apply to PHI we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:
If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, or for more information about the complaint process, contact: ***NY Bone & Joint Specialists/ All Sports Physical Therapy HIPAA Privacy Officer; 155 E 55th St Ste 5D; New York, NY 10022.*** All complaints must be made in writing. You will not be penalized for filing a complaint.
We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number ***(212) 759-4553.***

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370 Lexington Ave Ste 614
New York, NY 10017

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903 Lexington Ave
New York, NY 10065

Phone: (212) 759 - 4553 **www.nyboneandjoint.com** **info@nyboneandjoint.com**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

The privacy of your protected health information is important to us. We have provided you with a copy of our Notice of Privacy Practices. It describes how your health information will be handled in various situations. We ask that you sign this form to acknowledge you received a copy of our Notice of Privacy Practices.

If your first date of service with us was due to an emergency, we will try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

I have received the Privacy Notice for: New York Bone and Joint Specialists/ All Sports Physical Therapy

_____

Print Name

_____ _____

Patient's Signature or Personal Representative's Signature **Date**

_____

Patient's Signature or Personal Representative's Signature

For Office Use Only:

Staff should complete ONLY if Acknowledgment Form is not signed:

1. Does patient have a copy of the Privacy Notice? **[ ]** YES **[ ]** NO

2. If you answered "No" above, please explain why the patient did not sign an acknowledgment form and the practice's efforts in trying to obtain the patient's signature *(check all that apply):*

[ ] Patient Unable To Comprehend
[ ] Patient Communication Barrier
[ ] Legal Representative Not Available
[ ] Patient/ Legal Representative Left Before Signature Obtained
[ ] Emergency Admission/ Patient Not Present for Registration
[ ] Patient Bypassed Registration – Not Available
[ ] Other: _____

3. Completed by:

_____ _____

Name of Staff Member **Date**

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ADMINISTRATIVE OFFICE POLICY PHYSICAL THERAPY CANCELLATION POLICY:

Please be advised that we require no less than 24 hours notice when an office appointment is canceled. However, when your appointment falls on a Monday and needs to be canceled, our office voice mail indicates the date and time of the messages; please leave a message indicating your cancellation, or e-mail us to let us know at **frontdesk@nyboneandjoint.com**

If this "Cancellation Policy" is not followed, the patient will be billed and held responsible for a $50 Cancellation Fee, and your insurance company cannot and will not reimburse for this.

If you call during office hours to cancel, you should note the name of the receptionist you spoke to, and the date and time that you called to cancel.

We thank you for your cooperation.

_____

Patient Signature

_____

Print Patient Name

_____

Date