H&D Physical Therapy
NEW PATIENT ENROLLMENT

Last Name: First: M.I.

Address:

City: State: Zip Code:

Date of Birth: Marital Status: Student: Yes/No

Home Phone #: Work Phone #: Mobile Phone#:

Email:

Occupation/Employer:

Employer Address:

Is this injury related to an accident? Yes No Auto Accident? Yes No
Work Accident? Yes No

Description of accident:

In case of emergency, who should we call?

Name: Phone #:

INSURANCE INFORMATION (If other than self)

Name of Insured: Relationship to insured:

D.O.B Phone #: ( )

****Please make sure we receive a copy of your health insurance card****

Please read, initial and sign below:

_____ I authorize my insurance company to pay medical benefits directly to H&D Physical Therapy. I authorize the release of any requested information to my insurance company which may be necessary for evaluating claims. I agree to be responsible for the balances of payment that is NOT covered by insurance, the interest accrued for outstanding balances, and any late cancellations or "no show" fees.

_____ I have reviewed and received a copy of the Notice of Privacy Practices for H&D Physical Therapy (Form HD 1000) and give my permission to H&D Physical Therapy to use and disclose my health information in accordance with it.

_____ I agree to that if I must cancel an AM appointment, I will do so by 5pm the night before the scheduled visit. If I must cancel a PM appointment, I will do so by 10am on the day of the visit.

_____ I understand a failure to cancel on time (as stated above) or failure to show up for a scheduled appointment will result in a charge of $75, billed to me, not my insurance carrier. We may remove you from the treatment schedule if you "no-show" or "late cancel" THREE consecutive times.

____ I understand H&D shall not be liable for the disappearance, loss, theft of, or damage to my personal property.

Signature: Date:

H&D Physical Therapy
CREDIT CARD AUTHORIZATION FORM

The Programs of H&D Physical Therapy
www.hdphysicaltherapy.com

Name as it appears on card:

_____

I, _____ hereby authorize H&D Physical Therapy to charge my credit card for co-payments/co-insurance and for any unpaid balances. Any remaining credit on my account after all insurance reimbursements have been received will be refunded. I understand this form will not be divulged to any person not engaged in the professional use or maintenance of said files and all information will be kept confidential as required by our federal privacy policies.

Visa Account #: _____ Exp. Date:_____
MasterCard Account #: _____ Exp. Date:_____
Amex Account #: _____ Exp. Date:_____

Signature: _____ Date: _____

HD 1000 Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR PERSONAL HEALTH RECORD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Protecting your privacy is of paramount importance to us, and we have implemented procedures to safeguard the information included in your files.

Your Personal and Protected Health Information:
We may gather personal and health information from you, other health care providers and third-party payers. This information is used for treatment, payment and health care operations. The following describes the ways we may use and disclose your Protected Health Information:

•We may provide PHI about you to health care providers, other practice personnel, or third parties who are involved in the provision, management or coordination of your treatment care.
•We may use or disclose your PHI so that we can collect or make payment for the health care services you receive or are going to receive.
•We may disclose your PHI to any third party you designate in writing.
•We may disclose your PHI if we believe it is necessary to prevent a serious threat to your health and safety or the health and safety of the public.
•We may disclose your PHI to a government agency if we believe you have been a victim of abuse, neglect or domestic violence. We will make this disclosure if it is necessary to prevent serious harm to you or other potential victims, you are unable to agree due to your incapacity, you agree to the disclosure, or required by law.
•We may disclose your PHI to a health oversight agency for activities authorized by law.
•We may disclose your PHI as required by a court or administrative order, or under certain circumstances in response to a subpoena, discovery request or other legal process.
•We may release your PHI as necessary to comply with laws relating to Workers' Compensation or similar programs that are established by the law to provide benefits for work-related injuries or illness without regard to fault.
•Your PHI may be disclosed for military and veterans affairs, for national security and intelligence activities, or for correctional activities.
•We may use or disclose your PHI when required by law.
•We may use your name, address, phone number, e-mail, and your records to contact you with appointment reminder calls/emails, newsletters, postcards, greeting cards, information about physical therapy, H&D Health and Wellness services, or other related information that may be of interest to you.

Please note your rights regarding this information:

1. You are entitled to inspect and receive copies of your records upon written request.
2. You are entitled make a written request to amend your PHI files or put restrictions on certain uses and disclosure of PHI.
3. We accommodate any reasonable request, yet we retain the right to deny inclusion of amendments or use restrictions of your PHI.
4. You have a right to receive all notices in writing.
5. You have the right to request that we do not disclose your information to specific individuals, companies, or organizations. Any restrictions should be requested in writing.

H&D Physical Therapy Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Contact Person
For further information concerning our privacy practices or if you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Director of Physical Therapy
H&D Physical Therapy
12 East 46th St, 8th Floor
New York, NY 10017

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.