PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name_____Date: _____
Address_____ Apt #_____ City _____ Zip_____
Home Phone # (_____)_____ Social Security # _____
Gender: Female Male Date of Birth _____Age _____
Martial Status: Married Single Divorced Widowed Separated
Employer _____ Work Phone # (_____)_____
Work Address _____ City / State / Zip _____
Occupation _____
EMAIL_____

EMERGENCY CONTACT

Name _____ Relationship to Patient _____
Phone # (_____)_____ Address _____

How did you hear about us? Como supiste de nosotros ? (PLEASE CIRCLCE ONE)

O Friend O Online O Ad/Mail O Medical Office Referral O Walk-in

INSURANCE INFORMATION

PRIMARY INSURANCE_____ Insured ID # _____

Name of Insured _____ Insured Date of Birth _____
Relationship to Insured: Self Spouse Child Phone # (_____)

_____
Address _____ City / State / Zip _____

Was illness / injury connected with patient's employment? Yes No
Was illness / injury the result of an accident? Yes No
If yes, please explain_____
Referring Physician _____ Date of Script _____ Phone# (____)_____

AUTHORIZATION TO RELEASE INFORMATION
ASSIGNMENT OF BENEFITS / AGREEMENT / CONTRACT

I hereby authorize Optimal Rehabilitation OT & PT, PLLC. to release of any information pertinent to my case to Health Care Financing Administration or any carrier, adjuster, or attorney involved in this case.

I hereby instruct and direct my insurance company to pay by check made out and mailed to Optimal Rehabilitation OT & PT, PLLC. If my current policy prohibits direct payment to provider, I hereby also instruct and direct my company to make out the check to me and mail it as follows: **Optimal Rehabilitation OT & PT, PLLC 721 MELROSE AVENUE 10455** for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY**. This payment will not exceed my indebtedness to the above-mentioned assignee. **I hereby agreed to full responsibilities for all expenses and to pay any balance of said professional service charges over and above this insurance payment, as specified by my contract valid at the date of service.**

A photocopy of this Assignment shall be considered as effective and valid as the original.
I authorize the provider to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

OptiMAL Rehabilitation OT &PT, PLLC

721 MELROSE AVE
BRONX NY 10455

TEL:718-554-0064
FAX: 718-554-0221

ACKNOWLEDGMENT OF RECIEPT OF HIPAA NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the hospital and the facilities listed at the beginning of this Notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate written explanations of special privacy protections that apply to HIV related information and mental health information.

_____ _____

Signature of Patient or Personal Representative Print Name of Patient or Personal Representative

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_____ _____

Date Description of Personal Representative's Authority

(For internal use- where signature above cannot be obtained)

Except in emergency treatment circumstances, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we make a good faith effort to obtain written acknowledgment of the patient's receipt of the Notice of Privacy Practices on the first date after April 14, 2003 we provide treatment, products or services to the patient (including at the time of admission, or a first visit to the hospital department, or any first service contact with the patient). We must make a goods faith effort to obtain written acknowledgment when reasonably practicable following an emergency treatment situation. If such acknowledgment cannot be obtained, we must document our good faith effort to obtain the acknowledgment and why it was obtained.

Describe good faith effort to obtain written acknowledgment (including your name and the date)

1. _____

Name: _____ Date: _____

SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Optimal Rehabilitation OT & OT, PLLC.** for services furnished to me by provider.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Patient's Signature Date

_____ _____

THE ORIGINAL OF THIS FORM MUST BE PLACED IN THE MEDICAL RECORD

CONSENT/ AUTHORIZATION FORM

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

Optimal Rehabilitation OT & OT, PLLC's LEGAL DUTY

Optimal Rehabilitation OT & PT, PLLC .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 herein.

Consent for Treatment I authorize the above named provider (s), to perform the treatment/procedure(s) described below. I have been informed the reasons for the treatment/procedure(s), along with the expected benefits, risks, possible alternative methods of treatment, and possible consequences involved in the following:

_____

The treatment/procedure(s) were explained to me in detail and all my questions were fully answered. Understanding this, I authorize the above named provider (s) to perform such examinations, treatments, laboratory test, and to administer such medication as in his or her opinion, are necessary or advisable for me (or_____).
I also certify that no guarantee or assurance has been made as to the results that may be obtained.

Release of Medical Record In order to ensure proper follow-up and continuity of care, I agree that a copy of my medical record may be released to my physician, a designated referral physician, and/or the provider, if any, who referred me here.

Insurance Authorization I request that payment of authorized benefits be made to the above named provider (s) on my behalf, for any services provided to me. I authorize any holder of medical and other information about me to release to Medicare and its agents, any insurance company, any other third party payer, state medical assistant agency, or any other governmental or private payer responsible for paying such benefits, any information needed to determine these benefits for related services. I agree to pay for all charges not covered by a third party payer. I authorize a copy of this authorization to be used in place of the original.

USES AND DISCLOSURES OF HEALTH INFORMATION

Optimal Rehabilitation OT & PT, PLLC. uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, **Optimal Rehabilitation OT & PT, PLLC.** may use your personal health information t o contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you. **Optimal Rehabilitation OT & PT, PLLC.** may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes / research studies and for emergencies. We also provide information when required by the law. In any other situation, **Optimal Rehabilitation OT & PT, PLLC** policy is to obtain your written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

CONCERNS AND COMPLAINTS

If you are concerned that **Optimal Rehabilitation OT & PT, PLLC.** may have violated your privacy rights or if you disagree with any decisions we have made regarding, access or disclose my personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further info on **Optimal Rehabilitation OT & PT, PLLC.'s** health information practices or if you have a complaint, please contact Imanuel Fuzailov, DPT, 721 Melrose ave. Bronx,N.Y. 10455

PATIENT INFORMATION CONSENT FORM

I have fully read and understand **Optimal Rehabilitation OT & PT, PLLC.'s** Notice of Information practices. I understand that **Optimal Rehabilitation OT & PT, PLLC** 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 practice. I also understand that **Optimal Rehabilitation OT & PT, PLLC** will consider requests for restriction on a case by case basis, but does not have to agree to request for restrictions.

I hereby consent to the use and disclosure of my personal health information for the purposes as noted in **Optimal Rehabilitation OT & PT, PLLC's** Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at anytime.