DIRECTIONS
PHYSICAL THERAPY & ACUPUNCTURE

Date: ______________________________

Last Name:	First Name:
Address:	Apt or P.O Box:
City:	State:
Zip Code:	Date of Birth:
Phone Numbers	
Home:	Email:
Work:	
Cell:	

Emergency Contact

Last Name:	First Name:
Phone:	
Relationship:	

Employer Information

Name of Employer:	
Address:	Suite/Floor#:
City:	State:
Zip Code:	

Problem/Condition

Description of Problem:	
Referred by:	
Date of Onset:	
Is this a Pre-Existing Condition?	

Primary Insurance

Insurance:	ID Number:
Group Number:	Claim Number:
Deductible:	Max Annual Benefit:
Copay:	Coinsurance:
Subscriber Information:	
Subscriber's Name:	Subscriber Relation to Patient: ☐Self ☐Spouse ☐Parent ☐Other
Subscriber's Date of Birth:	

Secondary Insurance

Insurance:	ID Number:
Group Number:	Claim Number:
Deductible:	Max Annual Benefits:
Subscriber Information:	
Subscriber's Name:	Subscriber Relation to Patient: ☐Self ☐Spouse ☐Parent ☐Other
Subscriber's Date of Birth:	

Have you had P.T., O.T. or Chiropractic treatments this year? Yes/No. If yes, please indicate the type of treatment and the duration of treatment?

____

<u>Workers' Compensation/Motor Vehicle Injuries Only:</u>
Is your condition a result of a Work Injury or a Motor Vehicle Accident? – Yes/No
Do you currently have a lawsuit/case against the respective parties? – Yes/No

<u>For Medicare Patients Only:</u>
Are you currently receiving home care services? Yes/No
If yes, when will you be fully done with home care? __________________________
Do you have a home care discharge letter? Yes/No

Patient or Guardian Agreement:

☐ I acknowledge that Directions Physical Therapy & Acupuncture, PLLC may disclose protected health information for the purposes of payment, treatment and healthcare operations

☐ I understand that I am responsible for any balance due and owing Directions Physical Therapy & Acupuncture, PLLC for services rendered.

All Patients:

☐**Consent to Treatment**: I consent to receive outpatient rehabilitation therapy services and any ancillary services that are deemed medically necessary or appropriate by my physical therapist and/or treating physician. However, I am aware that the practice of rehabilitation therapy is not an exact discipline and I acknowledge that no guarantees have been made to me regarding treatment and the treatment results from the rehabilitation therapy.

Signature of Patient or Guardian: _________________________ Date: ____________

In conjunction with my care, I consent to allow the use of filming devices, such as camera or cell phone, for the purpose of enhancing my care. In addition, I consent to the transmittal of such filming device images or video to Directions Physical Therapy & Acupuncture, PLLC and/or the treating physician through email or text. I acknowledge that such film and related images will only be used or disclosed for treatment purposes, and that Directions Physical Therapy & Acupuncture, PLLC will not further use or disclose such film or images for any other purpose without my authorization or consent.

☐**Yes** ☐**No**

Financial Responsibility

I agree to pay Directions Physical Therapy & Acupuncture, PLLC all amounts that are due and owing for services provided which are not otherwise paid for by Medicare, a third party insurance plan, a third party payor, or other payor source on my behalf for services rendered. In the event that this account is referred to a collection agency or an attorney, the undersigned further agrees to pay all reasonable costs of collection including, but not limited to, reasonable attorney fees.

Patient/Guardian Signature: _____________________________ Date: ____________

Patient Notification Policy

Name: ____________________________________ Account#: ___________________

In compliance with the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule and our Notice of Privacy Practices, Directions Physical Therapy & Acupuncture, PLLC will not disclose your protected health information ("PHI") without your explicit authorization, except as permitted by law for the purposes of payment, treatment and health care operations. Furthermore, Directions Physical Therapy & Acupuncture, PLLC will limit the use, disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. Therefore, Directions Physical Therapy & Acupuncture, PLLC will only disclose your appointment information, such as reminders or cancellations, on an answering machine, voice mail, text message or e-mail, unless you inform us otherwise. This notice refers to Directions Physical Therapy & Acupuncture, PLLC as "us", and "our" and to the patient/guardian as "I", "my", "you", "your", and "yourself."

I, the undersigned, hereby authorize Directions Physical Therapy & Acupuncture, PLLC to disclose my appointment information by the following methods of communications and I assume all responsibility for ensuring that the methods of communication that I indicated below are secure, with password protections used where applicable:

Answering Machine: _______________________________
Voice Mail: ______________________________________
E-Mail: ____

Patient/Guardian Signature: __________________________________ Date: _________

If you choose to have your PHI communicated to individuals other than yourself, please accurately complete the information below and sign the authorization. I further agree to be responsible for notifying Directions Physical Therapy & Acupuncture, PLLC if any of the foregoing change.

I, the undersigned, hereby authorize Directions Physical Therapy & Acupuncture, PLLC, to disclose my PHI to the person(s) named below:

Name	Relationship	Phone#
Name	Relationship	Phone#
Name	Relationship	Phone#:

DIRECTIONS
PHYSICAL THERAPY & ACUPUNCTURE

Physical Therapy Attendance Policy

Directions Physical Therapy & Acupuncture, PLLC strives to provide the highest quality of care while attempting to accommodate each patient's schedule. Therefore, we provide each patient a reserved time slot with a specific therapist in order to minimize wait time and assure continuity of treatment. Consistent attendance and adherence to the planned treatment regimen is paramount to your care and recovery.

While we are sensitive to the fact that an emergency may occur, cancellations, tardiness and absentees reduce our ability to accommodate the scheduling needs of our patients. As such, we request your full cooperation with the following company policy:

- If a patient is more than 30 minutes late for an appointment and fails to notify the clinic of the tardiness, treatment may be cancelled and a cancellation fee charged for missing the appointment.
- A Scheduled Appointment MUST BE CANCELLED AT LEAST 24 HOURS IN ADVANCE or a cancellation fee will be charged for that appointment.
- Failure to show up for a scheduled appointment without providing the clinic advanced notification of your absence will result in a fee being charged for the appointment. Furthermore, 2 consecutive absences without advanced notification may result in the cancellation of all your remaining scheduled appointments; as such failures may negatively impact your treatment.
- ALL PATIENTS that cancel a scheduled appointment less than 24 hours in advance, are late to an appointment or absent from a scheduled appointment will be charged a $120 CANCELLATION FEE. THE PATIENT IS RESPONSIBLE FOR THE FEE, NOT THE INSURANCE COMPANY OR THIRD PARTY PAYOR. Please note that a cancellation fee may not be charged if the missed appointment is rescheduled within a week of the tardiness, absence or late cancellation and you do not have another appointment scheduled.
- All Cancellations and absences will be documented in your medical record and reported to your physician and insurance company or third party payor.
- Repeated failure to comply with this policy will result in your appointments being scheduled based on availability, which will require you to call for an appointment on the day you would like to receive therapy.
- **URGENT: If you wake up with a fever, cough, sore throat, etc (ANY or ALL symptoms related to COVID-19), please DO NOT COME IN. Phone the office at 212-757-1333 or email us at desk@dptaa.com to cancel your appointment and you can reschedule once you have confirmation that you DO NOT have COVID-19.**

By Signing below, I acknowledge that I have read the foregoing company policy and agree to its terms.

_______________________________ _________________________

Patient Acknowledgement/Signature Date

Directions Physical Therapy & Acupuncture, PLLC
57 West 57th Street, Ste 603
New York, NY 10019
212-757-1333
desk@dptaa.com

Credit Card Payment Authorization

I, ____, hereby authorize Directions Physical Therapy & Acupuncture, PLLC to charge my credit card for services rendered and/or products supplied.

Name on Card: ____

Card Type: ____

Credit Card#: ____

Expiration Date: _____________________ **Security Code:** ____________

Billing Zip Code: __________________

Print Name: ____

Signature: ____

Date: ____

DIRECTIONS
PHYSICAL THERAPY & ACUPUNCTURE

Consent for Acupuncture Treatment

While it is never our intention to bring anything of a potentially negative bent into a health and healing relationship, we, along with other health care providers and hospitals, are obligated by the state of New York to ask that you read and sign the following:

Treatment Authorization: I (Print Name) ____ Consent to acupuncture and herbal treatment and other procedures associated with Chinese medicine by Directions Physical Therapy & Acupuncture, PLLC and the acupuncturist and staff at Directions Physical Therapy & Acupuncture, PLLC. I understand that methods of treatments may include, but not limited to, acupuncture, moxibustion, cupping, electrical stimulation, herbal medicine, and nutritional counseling.

Informed Consent: Acupuncture has the effect of normalizing physiological functions, modifying the perception of pain and treating certain diseases and imbalances of the body. Most people experience a sense of well being and relaxation during and after the treatment. I have been informed that acupuncture is a safe method of treatment, but occasionally bruising, numbness or tingling at the site of the needle insertion may occur after treatment. Bruising is also a possible side effect of cupping. Rare side effects include dizziness or fainting, especially if the patient is overdue for a meal. Burns on the skin are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment, other side effects may occur.

I will notify the acupuncturist if I am or become pregnant since this will affect the treatment.

I do not expect the acupuncturist to be able to anticipate and explain all of the possible risks and complications of treatment. I wish to rely on the acupuncturist to exercise judgment during the course of treatment which, based upon the facts then known, the acupuncturist believes is in my best interests. I understand that all my records will be kept confidential and will not be released without my written consent. If cases are used for research or publishing purposes, identities, including personal and identifying information will be altered.

Medical Doctor: While Oriental Medicine has a great deal to offer as a health care system, it cannot totally replace the resources available through biomedical physicians. Consequently, it is recommended that you consult a physician regarding any condition or conditions for which you are seeking acupuncture or herbal medicine treatment.

To comply with Article 160, Section 82111.1(b) of NYS Education Law, we request that you read and sign the following statement.

I/We the undersigned, do affirm that _____________________________________ (Patient) has been advised by the acupuncturist and/or Directions Physical Therapy & Acupuncture, PLLC to consult a physician regarding the condition(s) for which such patient seeks acupuncture and/or herbal medicine treatment(s)

I also understand that it is my responsibility to inform Directions Physical Therapy & Acupuncture, PLLC who my primary care physician and specialists are, and of any treatments I have had or am now undergoing for my current conditions and that I should keep the physicians and practitioners I see informed on an ongoing basis. I also understand that it is very important to let my primary care physician know about any treatments performed at Directions Physical Therapy & Acupuncture, PLLC in order to properly and safely coordinate my care. My primary care physician is:

Name of PCP: ____ Specialty: __________________

Address: ____

Telephone/Fax#: ____

Signature of Patient: ____

Date Signed: ____