PATIENT INFORMATION

PATIENT NAME: ______________________________ DATE: ________________

ADDRESS: ____

CITY: ______________________ STATE: ______ ZIP: __________________

HOME PHONE: __________________ CELL: _________________________

BIRTHDATE: ________________ AGE: _________ SEX: ___________

SOCIAL SECURITY #; ________________ E-MAIL: _______________________

ARE YOU WORKING? YES OR NO WORK INJURY? YES OR NO

SPORTS INJURY? YES OR NO

****HAVE YOU TREATED AT ANY OTHER PHYSICAL THERAPY FACILITY THIS YEAR?**
YES OR NO

EMPLOYER/SCHOOL____

PRIMARY DOCTOR: _________________________ PHONE: _______________

REFERRING DOCTOR: _______________________ PHONE: _______________

DIAGNOSIS / COMPLAINT / INJURY: _____________________________________

DID YOU HAVE SURGERY? YES OR NO DATE OF SURGERY: ________________

DATE OF INJURY / ACCIDENT / ONSET: __________________________________

EMERGENCY CONTACT:____

RELATIONSHIP TO PATIENT: _____________________ PHONE:_______________

INSURANCE COMPANY NAME: ____

CLAIM # / POLICY ID#: _______________________ GROUP #: __________________

INSURED: _________________________ INSURED'S BIRTHDATE: ____________

ADJUSTER'S NAME: _________________________ PHONE: _______________

ASSIGNMENT OF BENEFITS

PATIENT NAME: ______________________________________

I IRREVOCABLY ASSIGN TO STRULOWITZ & GARGIULO, P.T., ALL MY RIGHTS AND BENEFITS, UNDER ANY INSURANCE CONTRACTS FOR PAYMENTS FOR SERVICES RENDERED TO ME, BY STRULOWITZ & GARGIULO, P.T. I IRREVOCABLY AUTHORIZE STRULOWITZ & GARGIULO, P.T. TO FILE INSURANCE CLAIMS ON MY BEHALF FOR SERVICES RENDERED TO ME. I IRREVOCABLY AUTHORIZE STRULOWITZ & GARGIULO, P.T. TO ACT ON MY BEHALF AND REPORT ANY SUSPECTED VIOLATIONS OF PROPER CLAIM PRACTICES TO THE PROPER REGULATORY AUTHORITIES.

THIS ASSISGNMENT OF BENEFITS HAS BEEN EXPLAINED TO MY FULL SATISFACTION AND I UNDERSTAND ITS NATURE AND EFFECT.

PATIENT SIGNATURE: ________________________________ DATE: ____________
(IF MINOR PARENT/GUARDIAN)

I, ________________________________, AM THE PARENT/GUARDIAN OF
(PARENT/GUARDIAN NAME)

__________________________________, WHO HAS BEEN REFERRED TO YOU FOR
(PATIENT'S NAME)

TREATMENT. I GIVE PERMISSION TO TREAT MY CHILD AT YOUR FACILTY.

IF I DO NOT ACCOMPANY MY CHILD, AND YOU NEED TO CONTACT ME TO DISCUSS

ANY ISSUES OR CHANGES, I CAN BE REACHED AT: ___________________________

STRULOWITZ & GARGIULO
PHYSICAL THERAPY & REHABILITATION
PATIENT INFORMATION CONSENT FORM

I HAVE READ AND FULLY UNDERSTAND STRULOWITZ & GARGIULO'S NOTICE OF INFORMATION PRACTICES. I UNDERSTAND THAT STRULOWITZ & GARGIULO 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 IN WRITING. I ALSO UNDERSTAND THAT STRULOWITZ & GARGIULO 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 STRULOWITZ & GARGIULO'S NOTICE OF INFORMATION PRACTICES. I UNDERSTAND THAT I RETAIN THE RIGHT TO REVOKE THIS CONSENT BY NOTIFYING THE PRACTICE IN WRITING AT ANY TIME.

____
PATIENT SIGNATURE

____
SIGNATURE (IF MINOR PARENT/GUARDIAN)

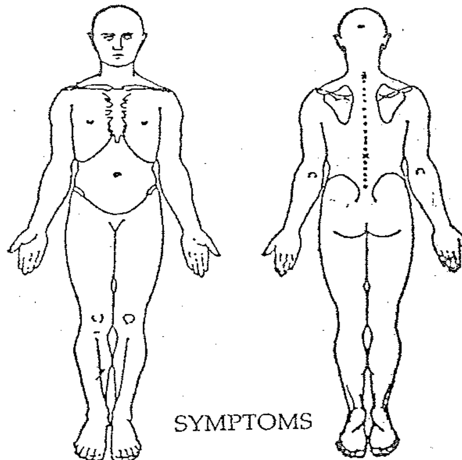
____
DATE

PATIENT NAME: ______________________________________ DATE: ________________

DOMINANT HAND: _______ AGE: _______ GENDER: _______ OCCUPATION:_________________________

PAIN: RATE INTENSITY (0= NO PAIN to 10 = EXTREME PAIN) AT REST: _____ DURING ACTIVITY: _____

1. PLEASE MARK/CIRCLE WHERE YOUR PAIN AND/OR OTHER SYMPTOMS ARE LOCATED.



2. WHAT ACTIVITIES DOES YOUR PAIN AND OTHER SYMPTOMS PREVENT YOU FROM DOING?
   a. ____
   b. ____
   c. ____

3. DESCRIBE HOW AND WHEN YOUR PROBLEMS BEGAN.
   ____
   ____

4. WHAT OTHER HEALTH PROBLEMS DO YOU HAVE?
   ____
   ____

5. WHAT MEDICATIONS ARE YOU TAKING?
   ____

6. ARE YOU CURRENTLY OR HAVE YOU IN THE PAST BEEN TREATED FOR ANY OF THE FOLLOWING? (YES OR NO):
   NECK PAIN_______ DIABETES ______ CANCER/TUMOR_______ HIGH BLOOD PRESSURE ______
   BACK PAIN_______ EPILEPSY________ ATHLETIC INJURY________
   VASCULAR INSUFFICIENCY _________________ CARDIAC OR HEART DISEASE ____________
   IS THIS A RECURRING INJURY? ______________

7. IS THERE ANY OTHER INFORMATION YOU WOULD LIKE TO PROVIDE US?
   ____
   ____

PATIENT'S SIGNATURE: ____________________ THERAPIST'S SIGNATURE:____________________________

STRULOWITZ & GARGIULO PHYSICAL THERAPY & REHABILITATION
NOTICE OF PATIENT INFORMATION PRACTICES

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.

Strulowitz & Gargiulo's LEGAL DUTY

Strulowitz & Gargiulo 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

Strulowitz & Gargiulo 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, Strulowitz & Gargiulo may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Strulowitz & Gargiulo may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Strulowitz & Gargiulo's 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.

Strulowitz & Gargiulo may change its policy time at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIEN"S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. 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. Strulowitz & Gargiulo will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Strulowitz & Gargiulo 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 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 information on Strulowitz & Gargiulo's health information practices or if you have a complaint, please contact the following person:

Strulowitz & Gargiulo Physical Therapy & Rehabilitation
Eleonora Donnelly, Office Administrator

One Nardone Place Jersey City, New Jersey 07306
201-792-3840 FAX: 201-792-7948

115 West 42nd Street Bayonne, NJ 07002
201-243-6662