OceanView REHABILITATION

3175 Emmons Ave. Brooklyn, N.Y. 11235

Patient Registration

Last Name: _____ First Name: _____

Address: _____

Home Phone: _____ Mobile Phone: _____

Sex: _____ Date of Birth: _____ Age: _____

Marital Status: _____

How Did you hear about us? (Please circle one of the following)

Doctor, Website, Live in the area, Friend, Google, Social Media, Other.

Emergency Contact

Last Name: _____ First Name: _____

Home Phone: _____ Mobile Phone: _____

Referring Doctor: _____ Phone: _____

Insurance Information:

Primary Insurance Company Name: _____

Policy Holder Name: _____ Policy holder's DOB: _____

Policy holder's Mailing Address: _____

Primary Insurance Company Name: _____

Member ID # _____ Group Number: _____

Policy Holder Name: _____ Policy holder's DOB: _____

Policy holder's Mailing Address: _____

Authorization To Release information and Assignment of Benefits:

LIMITATION OF LIABILITY-

Certain Insurance companies will only pay for services which the deem necessary. It is my understanding that it is the practice of this office to preform treatments which are deemed necessary and sufficient for the diagnosis of my condition. In the unlikely event my insurance company fails to pays either myself or this office for any of these necessary services, I agree to be financially responsible for payment,

REALEASR OF INFORMATION:

I permit this office to disclose all or part of this patient's medical record to any person, corporation, or agency when required for the collection of the benefits or upon request by referring physician

ASSIGNMENT OF BENEFITS:

I hereby authorize this office to apply for benefits on my behalf for covered services rendered by him/her, or by his/her order. I request that payment from my insurance company be made directly to DR. (or to the party who accepts assignment).

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in the place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

I certify that the information I have reported with regard to my insurance coverage is correct.

I confirm that I have read and fully understand the above information.

Patient Signature: _____

Print name: _____

Date: _____

Guardian Signature: _____

Relation of patient: _____

Date: _____

Name _____

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

I, [name of client) _____ hereby consents to the use or disclosure of his/her individually identifiable health information (Protected Health Information) by OCEAN REHABILITATION CENTER (facility) in order to carry out treatment, payment, or health care operations. Client should review facility's Notice of Privacy Practices for Protected Health Information (Notice) for a more complete description of the potential uses and disclosures of such information, and CLIENT has the right to review such Notice prior to signing this consent form.

The center reserves the right to change the terms of its Notice at any time. If the center does change the terms of its Notice, CLIENT may obtain a copy of the revised Notice by requesting it from **Aliza Klugman, Privacy Officer (Human Resources Office)**

CLIENT retains the right to request that the center further restrict how client's protected health information is used or disclosed to carry out treatment, payment, or health care operations. The center is not required to agree to such requested restrictions; however, if the center does agree to client's requested restriction(s), such restrictions are then binding on the facility.

At all times, client retains the right to revoke this Consent. Such revocation must be submitted to the center in writing. The revocation shall be effective ***except*** to the extent that the center has already taken action in reliance on the Consent.

The center may refuse to treat client if client (or an authorized representative) **does not** sign this Consent Form (except to the extent that the center is required by law to treat individuals). If client (or authorized representative) signs this Consent Form and then revokes Consent, the center has the right to refuse to provide further treatment to the client as of the time of revocation (except to the extent that the center is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE CLIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE CLIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE-STATED TERMS.

Date: _____

Signature of client _____

Signature of witness _____ Print Name _____

Person signing on behalf of client* _____ _____

Please print name

* Please explain Representative's Relationship to CLIENT and include a description of Representative's Authority to act on behalf of the CLIENT

_____

Please also be advised that information about your condition will only be given out to your designated representative. Should any other family member request detailed information it will not be given to them unless your request to release this information to them is submitted in writing to the Social Services Department or you may include their name here

Name: _____ Relationship to client: _____

Cancellation Policy

We are here to work together with you. We understand situations arise and emergencies happen that may cause you to cancel your appointment. **We kindly request that if you MUST cancel your appointment to please provide a minimum of 24 hours' notice**.

Patients that cancel with less than a 24-hour notification or do not show up to their appointment without any notification will be subject to a $30.00 cancellation fee.

The cancellation and no-show fees are the sole responsibility of the patient and must be paid in full before the patients next appointment.

Our facility firmly believes that good therapist to patient relationship is based upon a mutual understanding and good communication. Our sole purpose is to make sure we get you back to health and feeling well in a timely manner and that is dependent on you showing up for your appointments and fulfilling the plan of care the therapist provides for that week and that month.

Please sign that you have read, understand and agree to this policy.

_____

Patient Name (Print)

_____

Patient Signature

_____

Date

PHYSICAL THERAPY MEDICAL HISTORY FORM

PATIENT INFORMATION

NAME _____ DATE: _____

(LAST) (FIRST)

REHAB INFORMATION

1. MAIN COMPLAINT/AILMENT/INJURY: _____

_____

2. START DATE OF PAIN? _____

3. ANY PRIOR SURGERY? YES OR NO

IF YES, WHAT KIND AND DATE OF SURGERY: _____

4. MOTOR VEHICAL/JOB RELATED ACCIDENT: YES OR NO?

IF YES, DATE OF ACCIDENT: _____

5. HAVE YOU RECEIVED THERAPY FOR THIS CONDITION**?** YES OR NO

WHEN? _____ HOW MANY VISITS?

6. HAS YOUR CONDITION BEEN GETTING?11. WORSE PAIN SAME BETTER SINCE IT STARTED

7. CIRCLE THE NUMBER THAT BEST CORRESPONDS TO YOUR PAIN:

AT ITS LEAST: 0 1 2 3 4 5 6 7 8 9 10 (EXCRUCIATING PAIN)

AT WORST: 0 1 2 3 4 5 6 7 8 9 10 (EXCRUCIATING PAIN)

8. WHAT MAKES YOUR CONDITION **BETTER**? (CIRCLE ALL THAT APPLY)

SITTING	WALKING	HEAT	BETTER IN AM
STANDING	MOVEMENT	ICE	BETTER IN PM
STAIRS UP/DOWN	LYING	MEDICATION	BETTER AS DAY GOES ON
SIT TO STAND	WHEN STILL	CASE JUST REMOVED	
CHANGING POSITIONS	PROLONGED POSITION		OTHER:

9. WHAT MAKES YOUR CONDITION **WORSE**? (CIRCLE ALL THAT APPLY)

SITTING	WALKING	HEAT	WORSE IN AM
STANDING	MOVEMENT	ICE	WORSE IN PM
STAIRS UP/DOWN	LYING	MEDICATION	WORSE AS DAY GOES ON
SIT TO STAND	WHEN STILL	CASE JUST REMOVED	
CHANGING POSITIONS	PROLONGED POSITION		OTHER:

10. PREVIOUS MEDICAL INTERVENTION (CIRCLE ALL THAT APPLY) X-RAY MRI CTSCAN

11. Pain INJECTIONS/EPIDERAL/ CORTISONE/OTHER

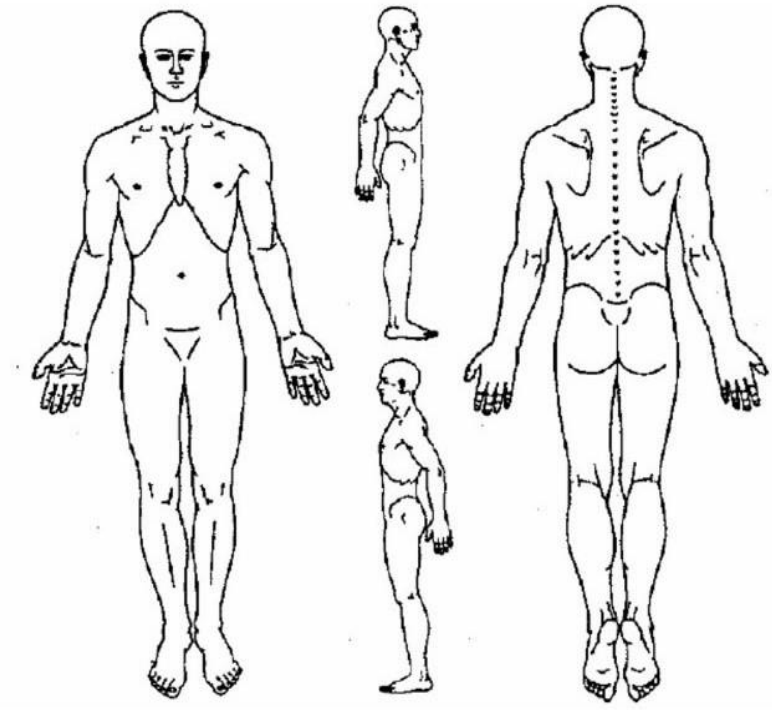
MEDICAL INFORMATION (CHECK OFF ALL THAT APPLIES)
(**THIS INFORMATION IS CONFIDENTIAL AND REMAINS PART OF YOUR CHART)

- ☐ DIFFICULTY WALKING
- ☐ FRACTURE (Please say where and what type): _____
- ☐ ARTHRITIS
- ☐ HIGH BLOOD PRESSURE
- ☐ HEART PROBLEMS
- ☐ PACEMAKER
- ☐ EPILEPSY/SEIZURE
- ☐ CANCER (PAST or CURRENT
- ☐ VERTIGO
- ☐ POOR BALANCE
- ☐ UNEXPLAINED WEIGHT LOSS
- ☐ BLOOD CLOTS/DVT (PAST or CURRENT)
- ☐ SHORTNESS OF BREATH
- ☐ HISTORY OF SMOKING
- ☐ DIABETES 1 or 2
- ☐ FIBROMYALGIA
- ☐ STROKE/CVA
- ☐ OSTEOPOROSIS
- ☐ PSYCHIATRIC DISORDERS
- ☐ BLEEDING PROBLEMS
- ☐ HIV/HEPATITIS
- ☐ LUNG PROBLEMS
- ☐ DEPRESSION/ANXIETY
- ☐ PREGNANT
- ☐ TRAUMATIC BRAIN INJURY
- ☐ ALZHIMERS
- ☐ PARKINSON

Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗



List all current Medications:

_____

Please list any Allergies:

_____