PATIENT INFORMATION

25 Smith Street Suite 202
Nanuet, NY 10954
P: 845-623-6333 F: 845-684-2640
www.HudsonHealthSpine.com

Thank you for choosing Hudson Health & Spine and/or Hudson Health Physical Therapy, PLLC. How did you hear about us?
□ Internet □ Family □ Friend □ Sign □ Promotion: _____ □ Patient: _____ □ Other: _____

PATIENT RESPONSIBILITIES to Hudson Health & Spine and /or Hudson Health Physical Therapy, PLLC
- Give accurate and complete health information concerning your past illness, hospitalizations, medications, allergies, pain and other pertinent information
- Provide accurate information about current insurance, billing information, and personal and update if there is any change.
- **All sections with * are required**

PATIENT INFORMATION						**(DATE: / /)**
Name:				Sex: M / F	DOB: / /	Age:
SSN: - -		E-mail:				
Home Phone:			Cell Phone:			
Home address:		City:		State:	Zip:	
Occupation:	Employer:		Work Phone:			
Work address:		City:		State:	Zip:	
□ Single	□ Married	□ Widowed	□ Divorced	□ Legally Separated	□ Domestic Partner	

INSURANCE INFORMATION				
Primary	Insurance name:	ID #	Group #	
	Insured's Name:		Insured's DOB: / /	
	Phone #:	SSN - -	*Relationship to Patient:	
2ndary	Insurance name:	ID #	Group #	
	Insured's Name:		Insured's DOB: / /	
	Phone #:	SSN - -	*Relationship to Patient:	

BILLING INFORMATION		□ Patient self		
Name:		DOB: / /	*Relationship to Patient:	
SSN - -	Home Phone:		Cell Phone:	
Address: :	City:		State:	Zip:

- ***EMERGENCY CONTACT :** _____ Relationship:_____ Phone : _____
- **PRIMARY CARE PHYSICIAN**:_____ Phone :_____

Office Address:_____City_____State_____Zip_____

- **PLEASE ANSWER THE FOLLOWING QUESTIONS**

1. Have you ever received Chiropractic care? □ No □ Yes If "Yes", When? _____
2. Have you ever received Physical Therapy? □ No □ Yes If "Yes", When? _____
3. X-Rays taken? □ No □ Yes If "Yes", When? _____ Body parts? _____
4. CT taken? / MRI taken? □ No □ Yes If "Yes", When? _____ Body parts? _____
5. Previous Motor Vehicle Accident? □ No □ Yes If "Yes", When? _____

6. Previous Work-Related Injuries? ☐ No ☐ Yes If "Yes", When? _____

7. Are you currently pregnant? ☐ No ☐ Yes

8. Exercise: ☐ None ☐ Light(1-2/week) / ☐ Moderate(3-4/week) / ☐ Daily(5-6/week)

Type : ☐ Cardio / ☐ Yoga / ☐ Pilates / ☐ Weights ☐ Other _____

9. Current Medications: ☐ None

Product Name	Symptoms	Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

10. Previous Surgeries: ☐ None ☐ Yes: _____

11. Previous Hospitalizations: ☐ None ☐ Yes: _____

12. Previous Significant Illnesses: ☐ None ☐ Yes: _____

13. Previous Injuries and Traumas: ☐ None ☐ Yes: _____

14. Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure
☐ Heart Problem ☐ Stroke ☐ Rheumatoid Arthritis

• CHECK OR CIRCLE ANY OF THE FOLLOWING THAT PERTAIN TO YOUR MEDICAL HISTORY & CURRENT SYMPTOMS

☐ Allergies _____
☐ Cancer:_____
☐ Fever
☐ Lyme Disease
☐ Anemia
☐ Bruise Easily
☐ Diabetes: Type I / ☐ Type II
☐ Thyroid Hypo / ☐ Hyper
☐ Depression
☐ Anxiety
☐ Fatigue
☐ Gallbladder Symptoms
☐ Kidney Problems
☐ Hepatitis / Liver Problems
☐ Gout
☐ Convulsions / ☐ Epilepsy
☐ Insomnia / ☐ Trouble Sleeping
☐ Loss of Memory
☐ Loss of Concentration

☐ Loss of Smell / ☐ Taste
☐ Buzzing / ☐ Ringing Ears
☐ Vision Blurred
☐ Dizziness / ☐ Vertigo
☐ Menstrual Pain / ☐ PMS

☐ Sinus Problems
☐ Ear Infections
☐ Bladder Infection
☐ Venereal Disease

☐ Constipation / ☐ Diarrhea
☐ Indigestion
☐ Tuberculosis
☐ Weight Loss
☐ Heart Trouble
☐ Chest Pain
☐ Cold, Tingling Extremities
☐ Fainting
☐ Heart Attack

☐ High Blood Pressure
☐ High Cholesterol
☐ Poor Circulation

☐ Arthritis: _____
☐ Headaches / Migraine
☐ Shoulder Pain
☐ Hip Pain
☐ Knee Pain
☐ Neck Pain
☐ Pain down to Arm(s)
☐ Low back Pain
☐ Pain down to Leg(s)
☐ Osteopenia
☐ Osteoporosis
☐ Scoliosis
☐ Multiple Sclerosis
☐ Stroke _____
☐ Parkinson's disease
☐ Other _____

IF YOU CHECKED OR CIRCLED ANY OF THE ABOVE, PLEASE EXPLAIN: _____

_____

_____

● **CHIEF COMPLAINT (MAIN REASON OF YOUR VISIT)**

▪ Is this visit ☐ Work related (WC claim#: _____) ☐ Motor Vehicle Accident related ☐ N/A

▪ Symptoms began on: Date: _____

▪ Describe your symptoms: _____

▪ How did your symptoms start? _____

▪ Have you seen any other Healthcare Provider for this condition? ☐ No ☐ Yes

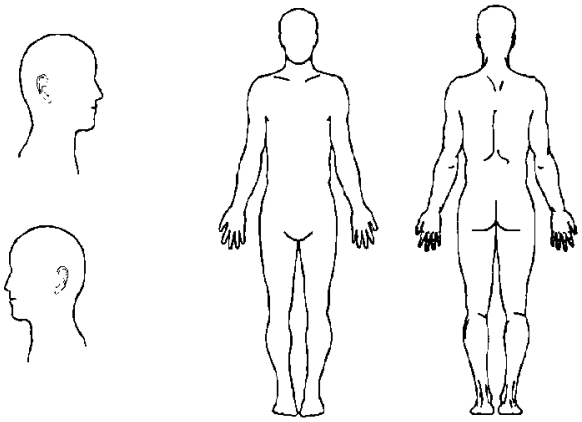
▪ If "Yes", who have you seen? Include Hospital/ER visits, and Provider name. _____

_____

▪ How often do you experience your symptoms? ☐ Constantly ☐ Frequently ☐ Occasionally ☐ Intermittent

▪ Onset characteristics: ☐ Occurred suddenly ☐ Occurred gradually ☐ Progressively worsened over time

INDICATE WHERE YOU HAVE PAIN OR SYMPTOMS



Use the following symbols, as applicable, to diagram areas of discomfort

A = Aching	N = Numbness
B = Burning	R = Throbbing
C = Cold	ST = Stabbing
SR= Sore	SH= Shooting
H = Hypersensitivity	T = Tingling

AVERAGE PAIN INTENSITY
(PLACE AN "X" ON THE SCALE)

◄----------►

0 1 2 3 4 5 6 7 8 9 10

No pain Severe

ACCOUNT INFORMATION AND TERMS OF ACCEPTANCE

I hereby authorize the Healthcare Professional to perform diagnostic tests and administer treatment as is necessary. I also authorize the release of my information as required to process any treatment, coordination of care, insurance claims and payment. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I authorize my carrier to send payment directly to Hudson Health & Spine and/or Hudson Health Physical Therapy, PLLC. I permit this office to credit my account upon receiving payment.

FINANCIAL OBLIGATION

I recognized that Hudson Health & Spine and/or Hudson Health Physical Therapy, PLLC will make every effort to assist me in obtaining insurance coverage. However, it is my responsibility to understand the up to date benefit coverage of my insurance. I understand that I am financially responsible for my health insurance deductible, coinsurance, copayment or non-covered services. In the event that my health plan determines a service to be "non-covered", I will be responsible for the complete charge and agree to pay the costs of all services provided. All payments are due at time of service. If the exact dollar amount has not been determined, I will be asked to pay the estimated amount and will be billed for the balance. If my plan requires a referral, I must obtain it prior to my visit. All balance notifications will be delivered via e-mail, mail, and/or phone calls.

APPOINTMENT AGREEMENT

_____ (Patient Initials) Please contact our office at least 24 hours in advance to reschedule or cancel your appointment. I am aware that I will be assessed a $50 penalty fee for a same day appointment cancellation except unexpected events or emergencies.

I understand the above information in its entirety and hereby guarantee that this form was completed accurately as to the best of my knowledge. I also understand that it is my sole responsibility to inform this office, in a timely manner, of any and all changes to this information. I hereby give my authorization to treat my minor as named herein on this form.

_____ _____ _____

Name of Patient (Print) or Legal Representative if patient is minor/Relationship | Signature of Patient/ Legal Representative | Date

NOTICE OF PRIVACY PRACTICES/ PATIENT RIGHT

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

The Hudson Health & Spine and/or Hudson Health Physical Therapy, PLLC is required by law to maintain the privacy and confidentiality of your protected health information.

DISCLOSURE OF YOUR HEALTH INFORMATION

This office uses and discloses your protected health care information for the following reasons:

- to share with other treating healthcare professionals regarding your healthcare.
- to submit to your insurance company or Workers Compensation claim to verify that treatment has been rendered.
- to determine patient's benefits in a health care plan.
- to assist in overcoming a language barrier when caring for a patient.
- to notify a family member or caretaker about your health condition or in the event of an emergency situation.
- as required by State, Federal or Public Health Law
- if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence.
- appointment date and time reminder to household members, answering machines, e-mail and/or texting.

Any other uses or disclosure will only be made with your specific written prior authorization.

* Check 1 of the following *

☐ Decline to disclose my Protected Health Information to anyone but myself.
☐ You may disclose my Protected Health Information to:

Name:_____ Phone:_____ Relationship:_____

THE PATIENT HAS THE RIGHT TO

- Be treated with consideration, respect and full recognition of his/her dignity and individuality
- revoke authorization, in writing at any time by specifying what you want restricted and to whom.
- speak to our privacy officer who is Dr. Joseph Taccetta and can be reached at 845-623-6333 regarding privacy issues.
- inspect, copy and amend your protected health information as allowed by law.
- request to receive confidential communications from us by alternative means or at an alternative location.
- obtain an accounting of any disclosures or to be notified of any breech of privacy of your protected health information.
- render a complaint to our privacy office or Secretary of Health and Human Services.

This/or These office(s) reserves the right to change the terms of this notice and to make new notice provisions for all protected health information that it maintains. Patients may obtain an updated copy at any time upon request.

I acknowledge that I have received and reviewed this notice with full understanding.

_____ _____ _____

Name of Patient (Print) or Legal Representative if patient is minor/ Relationship | Signature of Patient/ Legal Representative | Date

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RELEASE OF MEDICAL RECORDS:

I hereby give authorization for the release of my medical records to Hudson Health & Spine and/or Hudson Health Physical Therapy, PLLC

_____ _____ _____

Name of Patient (Print) or Legal Representative if patient is minor/ Relationship | Signature of Patient/ Legal Representative | Date

Hudson Health Physical Therapy, PLLC

Patient Consent Form for Physical Therapy

Patient Name (Print): _____ DOB: _____

*Please read this entire document. It is important that you understand the information contained in this document.

The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. Hudson Health Physical Therapy, PLLC does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical therapy treatment may result in burn, exacerbation of existing symptoms, fracture, pain, and other injury.

Physical therapy may involve certain risks, including, but not limited to, the following:

1. Muscle soreness: Physical therapy exercises may cause temporary muscle soreness and discomfort. This discomfort typically resolves within a few days.
2. Joint stiffness: Certain exercises and activities may cause joint stiffness, especially in patients with pre-existing joint conditions.
3. Falls: Some physical therapy activities may increase the risk of falls, especially in patients who have balance or coordination problems.
4. Aggravation of current condition: Physical therapy may cause temporary aggravation of my current condition, including pain, swelling, bruise or inflammation.
5. Adverse reactions to modalities: Some physical therapy modalities, such as heat, cold, or electrical stimulation, may cause adverse reactions in some patients, such as skin irritation, burns, or allergic reactions.
6. Delayed healing: In rare cases, physical therapy may delay the healing process, especially if the treatment is not appropriate for the patient's condition.
7. Serious injuries: While rare, physical therapy may cause serious injuries, such as fractures, dislocations, or nerve damage.

It is your responsibility to inform your previous medical history to physical therapist because it may require modification of treatment for the optimal result.
It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results.

I have read the explanation of the physical therapy. I have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment. Having been informed of the risks, I hereby give my consent to physical therapy.

X_____
Signature of Patient
or Legal Representative (if patient is minor)

Date: _____ Time: _____

X_____
Physical Therapist's Signature

Date: _____ Time: _____