ChangePhysicalTherapy

PATIENT INFORMATION

Last Name:	First:	MI:	DOB:	Age:
Home Address:				
City:		State:	Zip Code:	

Cell Phone #	Home Phone #	Office Phone #	E-mail Address

Employment Status: ☐ Employed ☐ Part-time student ☐ Full Time Student ☐ N/A

Employer/School Name:

How did you hear about us?

EMERGENCY CONTACT

Last Name:	First:	Relationship: Phone #:

REFERRAL INFORMATION

◯ Direct Access	◯ Referred by Dr.	
Address:		Phone #:
City:	State:	Zip Code:

INSURANCE INFORMATION

Primary Insurance Company:		ID #: Group #:
Address:		Phone #:
City:	State:	Zip Code:
Policy Holder (if other than patient) :		
SSN:	Relationship:	DOB:

I attest that, to the best of my knowledge, the above information is accurate and true.

Date: Patient's Signature:

Matthieu Laurent, PT
302 5th Avenue, 8th Floor- Suite 818, New York, NY 10001

ChangePhysicalTherapy

Medical History

REVIEW OF SYSTEMS:
Have you recently noticed any of the following? Please check each box that applies.

- ☐ Change in appetite
- ☐ Change in swallowing
- ☐ Balance loss
- ☐ Night sweats
- ☐ Ringing in ears
- ☐ Unintentional weight loss/gain
- ☐ Chills
- ☐ Lightheaded
- ☐ Heartburn /Indigestion
- ☐ Blood in urine/stools
- ☐ Change in bowel/bladder
- ☐ Pregnancy
- ☐ Fever
- ☐ Numbness
- ☐ Shortness of breath
- ☐ Fatigue
- ☐ Nausea/vomiting
- ☐ Chest pain
- ☐ Joint swelling
- ☐ Skin rashes
- ☐ Change in mood
- ☐ Dizziness/fainting
- ☐ Headache/migraine
- ☐ Unusual weakness
- ☐ Tingling/Burning
- ☐ Difficulty sleeping
- ☐ Loss of sensation
- ☐ Palpitation
- ☐ Cough
- ☐ Bruise/bleeding easily
- ☐ Change in vision
- ☐ Falls
- ☐ Memory issues
- ☐ Pain
- ☐ Vertigo
- ☐ Pain at night
- ☐ Headaches
- ☐ Menstrual changes
- ☐ Depression
- ☐ Pain on urination

☐ Others which are not listed above – please specify: _____

PAST/CURRENT MEDICAL HISTORY:
Have you ever been diagnosed with the following? Please check each box that applies.

- ☐ Cancer – any kind
- ☐ Chronic UTI
- ☐ Pneumonia
- ☐ Bone/joint infection
- ☐ Pelvis inflammatory disease
- ☐ Kidney infection
- ☐ Heart attack
- ☐ Heart valve issues
- ☐ DVT (blood clots)/ Emboli
- ☐ Arterial blocks
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Diabetes
- ☐ Eating disorder
- ☐ Migraines
- ☐ STD/AIDS
- ☐ Pregnancy
- ☐ Anemia
- ☐ Asthma
- ☐ Chronic bronchitis
- ☐ Emphysema
- ☐ Depression
- ☐ Tuberculosis
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Parkinsonism
- ☐ Gout
- ☐ Hearing Loss
- ☐ GERD/Reflux
- ☐ Stomach/duodenal ulcers
- ☐ Chest pain
- ☐ Stroke
- ☐ Epilepsy/seizures
- ☐ Ankylosing Spondylitis
- ☐ Rheumatoid arthritis
- ☐ Degenerative arthritis
- ☐ Headaches
- ☐ Osteoporosis/osteopenia
- ☐ Multiple sclerosis
- ☐ Endometriosis
- ☐ Urinary incontinence
- ☐ Skin abnormalities
- ☐ Blood disorders
- ☐ Liver problems
- ☐ Gall bladder issues
- ☐ Alcoholism
- ☐ Steroid use
- ☐ Muscular dystrophy
- ☐ Diverticulitis
- ☐ Birth defects
- ☐ Pacemaker/defib
- ☐ Metal implants
- ☐ Kidney problems
- ☐ Bladder problems
- ☐ Hernias
- ☐ Arrhythmias
- ☐ Fibromyalgia
- ☐ Spinal stenosis
- ☐ Head/Neck injury
- ☐ Joint replacement
- ☐ Glaucoma
- ☐ Substance abuse
- ☐ Fractures
- ☐ Dental work

☐ Others which are not listed above (for example, any upper body, back, and/or lower body injury) – please specify:

_____

_____

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ONLY FOR RUNNERS: PAST/CURRENT MEDICAL HISTORY (2):
Please answer the following questions:

1. Do you have any close family members who passed away suddenly before 50 years old? ( ) Yes ( ) No
2. Have you ever had any loss of consciousness, dizziness, thoracic pain or palpitations while exercising? ( ) Yes ( ) No
3. Have you ever had any respiratory problems (difficulty to breath, wheezing) or cough while exercising? ( ) Yes ( ) No

PAST/CURRENT SURGICAL HISTORY: Please check each box that applies and write in which year it was done.

	Year done		Year done
( ) Caesarean section		( ) Hysterectomy	
( ) Heart bypass		( ) Heart valve replacement	
( ) Prostrate surgery		( ) Appendectomy	
( ) Gall bladder surgery		( ) Bone surgeries	
( ) Joint replacement		( ) Carpal tunnel surgery	
( ) Back surgery		( ) Tonsillectomy	
( ) Reconstruction surgery		( ) Cosmetic surgery	
( ) Dental surgery		( ) Amputation	
( ) Eye surgery		( ) Ear surgery	
( ) Lung surgery		( ) Colonoscopy procedure	
( ) Abdominal surgery		( ) Oral endoscopy procedure	

( ) Others which are not listed above – please specify: _____

_____

What PHYSICIAN PRESCRIBED MEDICATIONS are you currently taking? Please check each box that applies.

	Dosage if known		Dosage if known
( ) Aspirin		( ) Anti-inflammatory drug	
( ) Tylenol/Acetaminophen		( ) Muscle relaxants	
( ) Pain medications		( ) Steroids	
( ) Birth control pills		( ) Hormone replacement	
( ) Blood pressure pills		( ) Water pills/Diuretics	
( ) Stomach ulcer medication		( ) Heart medications	
( ) Antibiotics		( ) Thyroid medication	
( ) Asthma medication		( ) Anti-depressants	
( ) Insulin		( ) Seizure medication	
( ) Decongestants		( ) Antihistamines	

( ) Others which are not listed above – please specify: _____
( ) I am NOT taking the following prescribed medications: _____

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What OVER-THE-COUNTER MEDICATIONS have you taken in the last week? How much and how often?

	Dosage if known		Dosage if known
( ) Advil/Motrin/Aleve/Ibuprofen		( ) Aspirin	
( ) Analgesics- Tylenol/Acetaminophen		( ) Antacids- Tums/Rolaids	
( ) Laxatives		( ) Decongestants	
( ) Antihistamines		( ) Tagamet/Zantac/Pepsid	
( ) Herbal medications		( ) Supplements (minerals)	
( ) Supplements (vitamins)		( ) Essential oils	
( ) Probiotics		( ) Street drugs	

( ) Others which are not listed above – please specify: _____

What skin or medication allergies do you have (if any)?

_____

Life style Questionnaire

1. Do you smoke? ( ) Yes ( ) No ( ) I stopped
   If Yes, how many cigarettes or packs a day? _____
   How long have you been smoking? _____
2. Do you drink alcohol? ( ) Yes ( ) No
   If Yes, how many times in the past year have you had 4 or more drinks in a day? _____
3. Do you drink caffeine? ( ) Yes ( ) No
   If Yes, how many drinks a day? _____

Patient's Name: _____

Patient's Signature: _____ Date: ___ / ___ / _____

ChangePhysicalTherapy

Notice of Advice - Direct Access Law

At the beginning of Direct Access Physical Therapy treatment, the Physical Therapist is obligated by New York State law (Chapter 298 of the Laws of 2006) to advise the patient of the possibility that their health care plan or insurer may not cover the treatment without a referral from a physician, dentist, podiatrist, or nurse practitioner and that the treatment may be a covered expense if rendered with a referral.

I attest that I have read and understood this Notice of Advice regarding New York State's Direct Access Law.

Date treatment will begin: ___ /___ /_____

Patient's Name: _____

Patient's Street Address: _____

City: _____ State: _____ Zip code: _____

Patient's Signature: _____ Date: ___ /___ /_____

Matthieu Laurent, P.T.: _____ Date: ___ /___ /_____

ChangePhysicalTherapy

Notice of Privacy Practices

Effective March 27th, 2019

Privacy Officer: Matthieu Laurent
302 5th Avenue, 8th Floor, Suite 818
New York, NY 10001
Phone: (646) 979-0905
Email: matthieulaurentdpt@gmail.com

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to Correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. • We will not retaliate against you for filing a complaint.

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • share information in a disaster relief situation *If you* are *not able to tell us your preference, for* example *if you* are *unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information* when *needed to* lessen *a serious and imminent threat to health or safety.*
In these cases we never share your information unless you give us written permission:	• Marketing purposes • Sale of your information
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	*Example: We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	*Example: We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways — usually in ways that Contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to Matthieu Laurent, P.T..

Privacy Officer: Matthieu Laurent
302 5th Avenue, 8th Fl, Suite 818
New York, NY 10001
Phone: (646) 979-0905
Email: matthieulaurentdpt@gmail.com

ChangePhysicalTherapy

Acknowledgement of Receipt of Notice of Privacy Practices

I have received the Notice of Privacy Practices for Matthieu Laurent, P.T.. I understand that I may request in writing any restrictions of the use of my protected healthcare information.

Date: ___ /___ /_____

Patient or Authorized Representative's Printed Name: _____

Patient's or Authorized Representative's Signature: _____

Received by:

Matthieu Laurent, P.T.: _____

ChangePhysicalTherapy

AUTHORIZATIONS & ACKNOWLEDGEMENTS

TREATMENT AUTHORIZATION: I authorize Physical Therapy treatment of myself or my minor child by the therapists and staff at Matthieu Laurent, P.T..

INFORMED CONSENT: The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition. Physical therapy involves the use of many different types of physical evaluation and treatment. At Matthieu Laurent, P.T. we use a variety of procedures to help us to try to improve your level of function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy. Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain therapy modality or procedure. We are not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain or injury, or may aggravate previously existing conditions. You have the right to ask your physical therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms and testing results. You may also discuss with your therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time before or during your treatment session. Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercises, your therapist will be glad to answer them.

AUTHORIZATION TO USE RECORDING DEVICES: In conjunction with my care, I authorize the use of recording devices, including, without limitation, a camera and/or mobile device to record videos and/or images for the purposes of enhancing my care. In addition, I authorize the transmittal of such recording device videos and/or images to my rehabilitation provider and/or the treating physician through secure email and/or text message. I acknowledge that such videos and/or images will only be used or disclosed for treatment purposes, and that my rehabilitation provider will not further use or disclose such videos and/or images for any other purpose without my written authorization.

CANCELLATION AND/OR NO-SHOW POLICY: Consistent attendance and adherence to the planned treatment regimen is paramount to your care and recovery. **In the event you need to cancel an appointment, we require at least 24 hours notice, excluding Saturday and Sunday.** Patients who cancel without proper notice or fail to show for a scheduled appointment will be subject to a **$50.00 charge** for each occurrence. Arrival more than 15 minutes after the time of

your scheduled appointment may be considered a failed appointment. **The patient is responsible for the cancellation fee, not the insurance company or third party payors.** Furthermore, 2 consecutive absences without proper notice may result in the cancellation of all your remaining scheduled appointments, as such failures may negatively impact your treatment plan.

RELEASE OF INFORMATION FOR INSURANCE BENEFITS: I hereby authorize and direct Matthieu Laurent, P.T. to release to government agencies, insurance carriers, or others, who are financially liable for my care, all information needed to substantiate payment for my care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

ASSIGNMENT OF BENEFITS: I authorize payment of my Insurance benefits to be made directly to Matthieu Laurent, P.T. on my behalf for physical therapy services rendered. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me, I will endorse such payments to Matthieu Laurent, P.T. within seven (7) days of receipt of such payment.

FINANCIAL/INSURANCE RESPONSIBILITY: I understand and agree to the following policies regarding financial and insurance responsibilities. Payment is required at or before each visit. I am responsible for charges incurred for all treatment rendered. This responsibility includes co-pay, co-insurance, deductible amounts, non-covered and excluded items not paid for by my insurance carrier or other party responsible for coverage of my medical expenses. I agree that I am responsible for any payments for services my insurance carrier determines, either now or at a later date, to be unreasonable or not medically necessary. I further understand, Matthieu Laurent, P.T. will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim. I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for Matthieu Laurent, P.T. to take action to secure payment of an outstanding balance owed.

FURTHER NOTICES AS TO POLICIES REGARDING MEDICARE: Matthieu Laurent, P.T. is a participating provider of Medicare; as such we will handle all billing to Medicare and any secondary insurance. Medicare requires you to satisfy a yearly deductible before they will begin paying benefits. Medicare will deduct the deductible amount from the first claim they receive each calendar year. Unless you have satisfied your annual deductible with another Medicare provider's office you are responsible to pay your deductible to Matthieu Laurent, P.T.. After your deductible is satisfied, Medicare will reimburse us 80% of their standard fee for Physical Therapy services. Therefore, your payment responsibility is 20% of the standard Medicare fee for Physical Therapy. Medicare has a financial allowance ($2,040 for 2019) for Outpatient Physical Therapy Services, which will cover you for approximately 15 treatments per year. There are two exceptions to this financial limit 1) you may choose to obtain your outpatient services at a hospital once you reach the $1,880 or 2) in certain circumstances, Medicare may grant a waiver of this limit based on specific criteria which we will detail after your initial evaluation. Therefore, unless you qualify for the Medicare or have additional insurance coverage, you will

be responsible for payment of any treatments in excess of the Medicare allowance. In addition, I understand that, in certain circumstances, Medicare may find that physical therapy services are not “reasonable and/or medically necessary” for the illness, injury or condition for which I am seeking treatment. I understand that Medicare bases this ruling on the diagnosis provided by my physician and their standards for that diagnosis. I understand, in this case, I will be responsible for any and all charged incurred.

NO GUARANTEES: I recognize that the practice of physical therapy is as much an art as a science, and therefore acknowledge that no guaranties have been or can be made regarding the likelihood of success or outcome of any therapy rendered at Matthieu Laurent, P.T.

REVOCATION OF AUTHORIZATIONS: These authorizations may be revoked by me, in writing, at any time. Such revocation will not affect my financial responsibility to pay for services rendered.

PATIENT ACKNOWLEDGMENT: I certify that the information I provide to my doctors, therapists and insurance company is correct. I certify that I am here to receive medical care and for no other purpose. I do not represent any third party. By signing and dating this form I acknowledge I have discussed, or have had the opportunity to discuss, with my therapist the nature and purpose of Physical Therapy treatment in general and my treatment in particular (including my Individualized Plan of Care) as well as the contents of these Acknowledgements and Authorizations. I consent to the Physical Therapy treatments offered or recommended to me by my Doctor and/or Physical Therapist. I intend this consent to apply to all my present and future Physical Therapy care at Matthieu Laurent, P.T..

Patient's Print Name: _____

Patient's Signature: _____ Date: ___ / ___ / _____

ChangePhysicalTherapy

Medical Information - HIPAA Release Form

Patient's Name: _____ Patient's Date of Birth: ___ /___ /_____

Release of Information

I authorize the release of all medical information rendered to me by Matthieu Laurent, P.T. This information may be released to:

( ) Spouse _____

( ) Child(ren) _____

( ) Other _____

( ) Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call: ( ) my home ( ) my work ( ) my cell number

If unable to reach me:

( ) You may leave a detailed message.

( ) Please leave a message asking me to return your call.

( ) You may send a text message.

The best time to reach me is (day) _____ between (time) _____

I authorize email communication to the following email address: _____

Patient's Signature: _____ Date: ___ /___ /_____

Matthieu Laurent, P.T.
302 5th Avenue, 8th Floor- Suite 818, New York, NY 10001