STRIDE
PHYSICAL THERAPY AND WELLNESS CENTER

Welcome to Stride Physical Therapy!

Today's Date____/____/____

Name _____Middle Initial_____

Home Address _____ Zip Code _____

Email Address_____

Home Phone # (____) _____ Work Phone # (_____) _____

Cell Phone # (____) _____

Social Security # _____ Date of Birth ____/____/____

Insurance Company_____ Member ID #_____

Insured Name _____ S.S. #_____ DOB: ___/___/___

Employer (Workers Comp. Patients) _____

Employer Address_____

Primary Care Doctor_____ Referring Doctor_____

Emergency Contact_____ Phone: _____

Current Medications_____

Medical Conditions/Precautions: _____

Reason for visit _____

How did you hear about us? _____

Please Note: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our office. Please note if a claim is submitted to an insurance company on your behalf, the health information on this form will be shared with your carrier.

89 5th Ave, Suite 1002 (10th floor), New York, NY 10003 Phone: 212-255-6355 Fax: 212-255-8355

STRIDE PHYSICAL THERAPY AND WELLNESS CENTER

Confidentiality Policy and Privacy Regulation

PATIENT NAME: _____

DO WE HAVE PERMISSION TO:

A) LEAVE A MESSAGE ON YOUR ANSWERING MACHINE AT HOME?

☐ YES

☐ NO

B) LEAVE MESSAGE AT YOUR PLACE OF EMPLOYMENT?

☐ YES

☐ NO

C) DISCUSS YOUR MEDICAL CONDITION WITH ANYONE OTHER THAN YOURSELF? (I.E MEMBER OF YOUR HOUSEHOLD)

☐ YES

☐ NO

D) OBTAIN HOSPITAL INFORMATION IF ADMITTED TO HOSPITAL?

☐ YES

☐ NO

_____ _____

PATIENT SIGNATURE DATE

_____

WITNESS SIGNATURE

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Stride Physical Therapy, P.C.
No Show/Cancellation Policy

Thank you for choosing Stride Physical Therapy as your physical therapy provider. We are sincerely dedicated in assisting you meet your therapy goals. In order to do this, it is important that you attend all scheduled therapy appointments. Consistent attendance allows you and your therapist to progress your treatment program which will result in quicker recovery and better outcomes.

We realize that there are times when unforeseen circumstances make it impossible to attend your scheduled appointment. If this happens, please give us as much notice as possible so we can reschedule your appointment and open that time slot for another client. If you are calling after hours you may leave a message at (212) 255-6355. Canceling an appointment with short notice or no-showing an appointment takes up clinic time that could benefit another person.

In order to enforce this policy, you will be charged $50 if you cancel an appointment less than 24 hours before your appointment time or do not show for an appointment. Your insurance does not cover charges for late cancellations or no-shows; it is the patient's responsibility. "No Showing" or canceling appointments without a 24 hour notice more than three times will unfortunately limit your ability to schedule advanced appointments and will result in same day scheduling only.

We want to make your physical therapy experience as beneficial as possible and your commitment is a very importance part of this. If you know you are going to have a difficult time making your appointments, please discuss with your therapist. We will try to accommodate your needs.
Thank you.

Patient/Parent/Legal Guardian Signature:

_____

Date: _____

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CONFIDENTIALITY POLICY

Health Insurance Portability Accountability Act 1996

Stride Physical Therapy, P.C. is committed to maintaining the confidentiality of its patients' **protected health information (PHI)**. PHI is any information, which relates to an individual's physical or mental condition, medical history, or medical treatment. PHI also includes any information obtained by *Stride Physical Therapy, P.C.* from which judgments can be made about a patient's character, habits, avocation, finances, occupation, general reputation, credit, health or any other personal characteristics. Such information includes a patient's name and address.

Consent obtained during the admission process to the *Stride Physical Therapy, P.C.* covers use and disclosure of PHI for purposes of treatment, payment and healthcare operations, including quality assessment and measurement, and disease management activities. Before any PHI is disclosed for purposes of treatment, payment or healthcare operations, agreements with the recipients of such information are entered into to protect the confidentiality of PHI. If a patient is unable to give consent, family or legally appointed representatives will be authorized to release and/or receive access to information about the patient.

All patients have the **right to access**, obtain copies (within 30 business days of a request), and correct any PHI about them, which is in *Stride Physical Therapy, P.C.* possession.

Use and disclosure policy of your medical information in the following categories:

Treatment: In diagnosing and treating your injury or illness, we may disclose all or any portion of PHI to attending physicians, consulting physicians, nurses, technicians, medical students, interns, residency programs, continuing education training, to a home health agency or hospital to coordinate specific services, such as prescriptions, lab work and x-rays, and to other health care providers who have a legitimate need for such information in your care and continued treatment.

Payment: We may use and disclose your medical information so that the services and treatment may be billed to, and payment may be collected from, your health insurer, HMO, or other company that arranges or pays the cost of your healthcare.

Healthcare Operations: We may use and disclose your medical information for internal administration and planning that improve the quality and cost-effectiveness of the care that we deliver to you, for example: performance improvement, utilization review, internal auditing, accreditation, certification, licensing, educational, and credentialing activities. We may remove information that identifies you from this set of medical information so others may use it to study health care and healthcare delivery without learning your identity.

Business Associates: A Business Associate is an individual or entity under contract with us to perform or assist us in a function or activity which necessitates the use or disclosure of medical information for example: a medical record copy service, consultants, accountants, lawyers, medical transcription and

third party billing companies. We require Business Associates to submit a written statement as to how they will protect the confidentiality and dispose of the PHI when use has been completed.

Use and disclosure policy of your medical information continued:

We may disclose medical information for the following: 1) to report health information to authorities for the purpose of preventing or controlling disease, injury or disability; 2) to report child abuse and neglect; 3) to report information about products under the jurisdiction of Federal Drug Administration; 4) to alert a person who may have been exposed to a communicable disease; 5) to report information to your employer as required under laws addressing work-related illness and injuries or workplace medical surveillance; 6) to notify the appropriate government authority if we reasonably believe you are a victim of abuse, neglect or domestic violence; 7) to facilitate organ, eye, or tissue procurement, for the purpose of tissue donation and transplant; 8) to Medicare and Medicaid to monitor the healthcare system and compliance; 9) to the police or other law enforcement officials in response to a valid subpoena or court order; 10) to a coroner or medical examiner or funeral director as authorized by law; 11) to comply with laws in regards to workers' compensation.

Authorization:

Any other uses and disclosures of your medical information will be made only with your authorization. If you provide permission to use medical information you may revoke that permission, in writing, at any time.

Individual patient rights regard to Protected Health Information (PHI):

- ✓ To inspect and copy (obtain a record request form from the Medical Records Department)
- ✓ To amend (obtain a request to amend form from the Medical Records Department)
- ✓ To have an accounting of uses and disclosures made by us, provided that such a period does not exceed six years
- ✓ Request restrictions on our use and disclosure (we are not required to agree to a requested restriction). Request confidential communications i.e. you may request that we contact you at work or by mail
- ✓ To obtain this notice in a paper copy
- ✓ To report a violation of your privacy rights to the Privacy Officer as well as to file a written complaint with the Director, Office of Civil Rights of the U.S. Department of Health and Human Services
- ✓ To be informed of any changes to the Privacy Policy. See new notices or changes posted in waiting areas around our premises
- ✓ The right to request a copy of changes to the Privacy Policy.

We emphasize the importance of confidentiality through employee training, the implementation of procedures designed to protect the security of our records, and our privacy policy. We restrict access to PHI to those employees who need to know that information to perform their job responsibilities. We maintain physical, electronic, and procedural safeguards that comply with federal and state regulations to guard the confidentiality of Protected Health Information.