Premier Physical Therapy & Nutrition of Long Island

Date: _____

First Name: _____ Last Name: _____

Date of Birth:_____ Age:_____ Gender:_____

Street Address :_____ City:_____

State:_____ Zip Code: _____

Home Phone #:_____ Cell Phone #:_____

Preferred contact method:_____ Email: _____

Employer:_____ Employer Phone # :_____

Address of
Employment:_____

Occupation:_____

Primary Insurance:_____ ID number:_____

Name of Policy Holder:_____ DOB of Policy Holder:_____

Relationship to Policy Holder:_____

Address of Policy
Holder:_____

_____

Secondary Insurance:_____ ID number:_____

Name of Policy Holder:_____ DOB of Policy Holder:_____

Relationship to Policy Holder:_____

Address of Policy
Holder:_____

_____

Premier Physical Therapy & Nutrition of Long Island
Nutrition & Health Questionnaire

Reason for Visit/Health Goals:

_____

_____

Diagnosis/Health Concerns:

_____

_____

_____

Past Medical History (please check all that apply)

□ Diabetes (type 1 or 2)_____
□ Prediabetes/abnormal blood sugar
□ Gestational Diabetes
□ Polycystic Ovarian Disease
□ High Blood Pressure
□ High Cholesterol
□ Kidney Disease (Stage)_____
□ Cancer (type) _____
□ Sleep Apnea
□ Bariatric Surgery (type)_____
□ Liver Disorder (specify)_____
□ Blood Disorder (specify)_____

□ Eating Disorder (specify type)_____
□ Depression/Anxiety
□ Gastrointestinal Disorder
(specify)_____
□ Food Allergies/Intolerances
(specify)_____
_____
_____
_____
□ Other
_____
_____

Medications & Dosages

_____

_____

_____

Vitamins & Supplements

_____

_____

Date of last Physical_____ Lab Results (if known). Do Not need to fil out if have copy of labs_____

Primary Care Physician _____Phone #_____

Address of Primary Care Physician_____

Name of Specialist _____ Specialist Type _____Phone # _____
Name of Specialist _____ Specialist Type _____Phone # _____

Height _____ Weight _____Highest Weight as Adult_____ Lowest Weight as Adult_____

Authorization for Release of Information

I, _____ hereby authorize my physician, and/or therapist to release/disclose any medically relevant information to Premier Physical Therapy & Nutrition of Long Island. This could include any blood work, medical test results or discussion with the physician and/or therapist.

Primary Care Physician_____

Specialist
(s):_____
_____

Psychologist/Therapist:_____

By signing this form, you authorize the use or disclosure of your protected health information as described above. Premier Physical Therapy & Nutrition of Long Island abides by all HIPAA regulations. You have the right to receive a copy of this form after you have signed it. You also have the right to revoke this authorization at this time.

I have read this form and all of my questions above have been answered. By signing below, I acknowledge that I have read and accept all of the above and I allow Premier Physical Therapy & Nutrition of Long Island to contact any or all of the parties stated above on an ongoing basis.

Signature (or signature of personal representative)

_____ **Date** _____

Print Name (or print name of personal representative and relationship to patient)

_____ **Date**_____

Premier Physical Therapy & Nutrition of Long Island

Notice of Privacy Practices
Patient Acknowledgement

Patient Name_____ **Date of Birth**_____

I have received this practices Notice of privacy practices. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practices legal duties with respect to my protected health information. The notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes; treatment, payment, and health care operations.
- A description of uses and disclosures that will be made only with my written authorization and that I may revoke such authorization
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  - The right to complain to this practice and to the secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
  - The right to request restriction on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communication of protected health information
  - The right to inspect and copy protected health information
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature (or signature of personal representative)

_____ Date_____

Print Name (or print name of personal representative and relationship to patient)

_____

Premier Physical Therapy & Nutrition of Long Island

Welcome to Premier Physical Therapy & Nutrition of Long Island! I am glad to have the opportunity to work with you to achieve your health/nutrition goals. The following policies have been established to assist our work together. Please feel free to ask any questions. It is our intention to partner with you to deliver optimal health and nutrition.

Confidentially

All sessions are confidential. Paperwork outlining privacy practices for this office is presented and signed during the initial session.

Appointments

Initial consult and comprehensive sessions are typically 60 minutes. Follow-ups are 30-60 minutes, all appointments are scheduled in advance. I will make every effort to begin sessions on time and appreciate that we work together to end on time as well. Consideration for all scheduled appointments is necessary. If you are late to an appointment you may use the remaining time of scheduled appointment but not exceed allotted time. Payments will be based on how an appointment was scheduled.

Cancellations

24 hour notice is required for all cancellations. There is a $40 dollar fee for all appointments not cancelled within this time frame.

My signature certifies that I have read and completed this form to the best of my ability. I understand that if my insurance denies coverage for nutritional counseling or rejects a submitted claim for any reason I am responsible for 100% of the payment. I understand that the recommendations and education provided by Premier Physical Therapy & Nutrition of Long Island should not be used in place of medical advice.

_____ _____

Signature Date