



# BRILL PHYSICAL THERAPY

1585 Broadway, 8<sup>th</sup> Floor, New York, NY 10036 (212) 761-6304  
11 Madison Avenue, Level 1B, New York, NY 10010 (212) 325-0961  
2000 Westchester Avenue, Purchase, NY 10577 (212) 761-6304

## REGISTRATION FORM

Date: \_\_\_\_\_

|  |
|--|
| 1. Patient Name: _____   |
| 2. Address: _____  |
| 3. City: _____ State: _____ Zip: _____                                   |
| 4. Date of Birth: _____ Social Security #: _____                         |
| 5. Work #: _____ Cell#: _____ Home#: _____                               |
| 6. Email: _____  |
| 7. Marital Status: Married Single Widowed Divorced                       |
| 8. Student: Yes No   |
| 9. Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female |

|   |
|---|
| 10. Employer Name: _____                |
| 11. Employer Address: _____             |
| 12. City: _____ State: _____ Zip: _____ |

|   |
|---|
| 13. How did you find out about Brill Physical Therapy?<br>Friend Promotional Material Walk in Website |
| Name of referring Physician: _____ (required for PT)  |
| Address: _____  |
| City: _____ State: _____ Zip: _____ Tel # _____   |
| 14. Date of Illness/Accident: _____   |
| 15. Purpose of visit (DX): _____  |
| 16. Have you seen another physical therapist this year? Y / N If so, how many visits were used? _____ |

### Staff Only

|   |
|---|
| 17. Primary Insurance Company: _____ Tel # _____      |
| 18. Policy Holder: _____ Self Spouse/Partner Guardian |
| 19. D.O.B _____ SS# _____ Tel # _____                 |
| 20. Policy # _____ Group # _____                      |

|                                    |                       |                        |
|------------------------------------|-----------------------|------------------------|
| Date: _____                        | In Network            | Out of Network         |
| Eff date: _____                    |                       |                        |
| Deductible: _____                  | Ded Met?: _____       | Out of pocket: _____   |
| Benefits: _____ % Co Insur _____ % | Co-payment/Fee: _____ | Visits per year: _____ |
| Precert/Auth required: _____       | Phone # _____         |                        |
| Name of insurance rep: _____       |                       |                        |
| Verified By: _____                 | Date: _____           |                        |
| First appointment: _____           | Time: _____           | Therapist: _____       |
| Notes: _____                       |                       |                        |
| _____                              |                       |                        |
| _____                              |                       |                        |



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### General Patient Information

Name: \_\_\_\_\_

Occupation: \_\_\_\_\_

Off work because of current episode: Yes / No Since: \_\_\_/\_\_\_/\_\_\_

### History of Present Complaint

Describe relevant symptoms: \_\_\_\_\_

Present since \_\_\_/\_\_\_/\_\_\_ Improving / unchanging / worsening

Commenced as a result of: \_\_\_\_\_ or no apparent reason

What makes it:

Better: \_\_\_\_\_

Worse: \_\_\_\_\_

Previous treatments: \_\_\_\_\_

X-Rays: Yes / No MRI: Yes/No Results: \_\_\_\_\_

### Medical Health Questionnaire

Circle any of the following symptoms that you have experienced in the past month:

|                  |           |                         |          |
|------------------|-----------|-------------------------|----------|
| Loss Of Appetite | Headaches | Shortness of Breath     | Fever    |
| Nausea           | Vomiting  | Change in Bowel/Bladder | Chills   |
| Swelling         | Sweats    | Bruising/Bleeding       | Weakness |
| Lightheadedness  | Rash      | Dizziness               | Vertigo  |
| Numbness         | Anxiety   | Weight loss             |          |

Circle any of the following that you have:

Pacemaker  
Diabetes  
Cancer or history of Malignancy  
Osteoporosis

Recent or major surgery: Yes / No Date: \_\_\_/\_\_\_/\_\_\_ Details: \_\_\_\_\_

Accidents: Yes / No Date: \_\_\_/\_\_\_/\_\_\_ Details: \_\_\_\_\_

Unexplained weight loss: Yes / No



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PATIENT AGREEMENT FORM

Thank you for electing Brill Physical Therapy. In order to facilitate your treatment here we ask that you read and sign this agreement and authorization.

- A scheduled appointment must be cancelled at least **24 hours in advance**, otherwise the full treatment fee of \$150 will be assessed.
- Fees due to Brill Physical Therapy for co-payment, deductible, cancellation fees and treatment fees not covered by pre-approved medical insurance plan are to be paid prior to treatment.
- We accept advance payments for all co-payments in accordance with treatment plan.
- We will bill your insurance carrier as a convenience to you, however if your carrier reimburses you, you agree to inform us of the receipt and pay us promptly.
- If your care is not covered by insurance, you agree to be responsible for payment of all fees in full.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

CONSENT FOR MEDICAL TREATMENT

I hereby authorize and request Brill Physical Therapy to provide such medical care and administer procedures and treatments as in the judgment of the physical therapists in attendance and deemed necessary and advisable.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

AUTHORIZATION FOR RELEASE OF INFORMATION FOR INSURANCE BENEFITS

I hereby authorize and direct Brill Physical Therapy, having treated me, 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.

\_\_\_\_\_  
Insurance Company

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

ASSIGNMENT OF BENEFITS

I hereby assign, transfer and set over to Brill Physical Therapy and the Therapist responsible for my treatment sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers or others who are financially liable for medical care to cover the costs of the care and treatment rendered to myself or my dependent in said facility. I understand that I am financially responsible for the charges not covered by my insurance. A Photostatted copy of this authorization shall be considered as effective and valid as the original. When signed by a Medicare recipient this is a lifetime care authorization. This authorization may be revoked by either myself or the above named carrier at anytime in writing.

\_\_\_\_\_  
Insurance Company

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date



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### PRIVACY AUTHORIZATION

This authorization is required by the privacy regulations recently promulgated by the United States Department of Health and Human Services.

Your protected health information including individually identifiable information, such as names, dates, phone/fax numbers, email address, demographic data, photographs, x-rays, and study models may be used or disclosed for the purpose(s) of:

- Lectures/presentations;
- Publications;
- Research;
- Practice Marketing; and/or
- Other (specify): \_\_\_\_\_

This information will be disclosed by the following people: Brill Physical Therapy Staff

The information will be disclosed to the following people/entities: Those listed above.

You have the right to revoke this Authorization at any time in writing. However, your revocation will not be effective to the extent that this Authorization has been relied on.

The information used or disclosed per this Authorization may be subject to re-disclosure by the recipient(s), and this, no longer protected by the privacy rules.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Witness Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date



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### **PRIVACY CONSENT**

This form is required by the new patient privacy regulations recently issued by the United States Department of Health and Human Services. Prior to commencing your physical therapy treatment, you must review, sign, and date this form.

Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, email addresses and demographic data) may be used in connection with your treatment, payment of your account or health care operations (i.e., performance reviews, certification, accreditation and licensure).

You have the right to review our office's privacy notice prior to signing this Consent, a copy of which was given to you with this Consent.

You have the right to request restrictions on the use of your protected health information. However, we are not required to, and may not, honor your request.

We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes and the changes may not be implemented prior to the effective date of the revised notice.

You may revoke this consent at any time in writing. However, such a revocation will not be effective to the extent that any action has been taken in reliance on this Consent.

Thank you for your cooperation. Please let us know if you have any questions.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Witness Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date



## BRILL PHYSICAL THERAPY

11 Madison Avenue, Level 1B, New York, NY 10010 (212) 538-6646  
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### Notice of Advice:

I have been informed of the possibility that physical therapy treatment may not be covered by my health care insurer without the referral of a physician, dentist, podiatrist, or nurse practitioner, but may be a covered expense, if treatment was rendered pursuant to such referral.

Treatment will begin on: \_\_\_\_\_  
Date

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

I have received a copy

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Therapist Name: Margaret W. Brill, P.T.

License # 011952-1

Address: 11 Madison Avenue, Level 1B New York, NY 10010

Therapist Signature: \_\_\_\_\_

Date: \_\_\_\_\_



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Please be advised that payment is due at the time of service for each Physical Therapy session. If you do not wish to pay each time, you may pay for the sessions in advance or have your credit card information on file.

If you would like to have your Credit Card on file please fill out the information below:

**We accept Visa, MasterCard, Discover & American Express**

Credit Card #: \_\_\_\_\_ EXP Date: \_\_\_\_\_

Cardholder's Name: \_\_\_\_\_  
(Please Print)

As a courtesy, our office submits claims to your insurance carrier on your behalf. Should your insurance company reimburse you directly, you agree to deposit the check(s) and authorize Brill Physical Therapy to automatically charge this credit card on file the exact amount(s) that was issued for each date of service.

I have agreed to the terms listed above and I authorize Brill Physical Therapy to charge my fee(s) to the Credit Card I have listed above for all future sessions unless stated otherwise.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

OR

If you choose to make an advanced payment by check please make check payable to:  
**BRILL PHYSICAL THERAPY**