**Kingston Physical Therapy & Sports Rehab., P.C.**

340 Plaza Road
Kingston, NY 12401
Tel: 845-339-4722
Fax: 845-339-5730

404 Zena Road
Woodstock, NY 12498
Tel: 845-679-4318

*www.KingstonPT.com*

# Patient History

NAME: FIRST LAST

ADDRESS:

CITY / STATE / ZIP:

HOME PHONE #: ( ) - SSN# - - SEX M / F

BIRTH DATE: PRIMARY CARE M.D.

MARITAL STATUS: S / M / OTHER STUDENT F / P EMPLOYED: Y/N

OCCUPATION: WORK PHONE#:

## PRIMARY INSURANCE:

COPAY AMOUNT:

ADDRESS: CITY / STATE / ZIP:

INSURANCE I.D.# GROUP#:

EMPLOYER OF INSURED: INSURED NAME/RELATIONSHIP TO: INSURED:

EMPLOYER ADDRESS: CITY / STATE / ZIP:

## SECONDARY INSURANCE(if applicable):

ADDRESS: CITY / STATE / ZIP:

POLICY#: GROUP#: RELATIONSHIP TO INSURED:

LIABILITY?: Y/N IF YES, NAME AND ADDRESS OF ATTORNEY:

I understand that I will be responsible for all charges denied by my insurance company and agree to pay all Collection Fees arising from noncompliance with this contract.

Further, I understand that I have complete access to Kingston Physical Therapy & Sports Rehab PC's ("The Practices") Notice of Privacy Practices. Should I have any questions regarding the Notice of Privacy Practices, I understand that I can contact the Practice's Privacy Officer at 845-339-4722.

*Signature of Patient or Parent/Guardian if under 18:_____* Date:_____

See reverse side for Medical Records Release

I,_____ , hereby authorize Kingston Physical Therapy and Sports Rehab, P.C. to (check those that apply):

__ use the following protected health information, and/or

__disclose the following protected health information to [Name of entity to receive information]:

[Specifically describe the information to be used or disclosed, including, but not limited to, meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.]

This protected health information is being used or disclosed for the following purposes:

[List specific purposes here.]

This authorization shall be in force and effect until [specify (1) date or (2) event that relates to the patient or the purpose of the use or disclosure] at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Mark Garcia at 340 Plaza Road, Kingston, New York 12401. I understand that a revocation is not effective to the extent that Kingston Physical Therapy and Sports Rehab, P.C. has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Kingston Physical Therapy and Sports Rehab, P.C. will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.), and/or
- Refuse to sign this authorization.

[The use or disclosure requested under this authorization will result in direct or indirect remuneration to the Kingston Physical Therapy and Sports Rehab P.C. from a third party.] [If use or disclosure involves marketing.]

_____
Signature of Patient or Personal Representative

_____
Date:

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority