MANHATTAN PHYSIO GROUP
Physical Therapy and Wellness Center

Our Affiliates

Amie J. Castaldo, L.Ac.
Anna Hajosi, L.Ac.
B.Payne.free Therapeutic Massage

Thank you for taking the time to provide us with the information on this form. Your answers help us to understand your condition, provide the best care possible, and meet the high standards that we believe in at Manhattan Physio Group.

Full Name: ______________________________

Administrative:
In order to serve you better, please let us know which days of the week and general times of the day are best for you to make follow up appointments:

- ____

Who is Your Referring Physician (If Any): ____________________________________

Current Condition

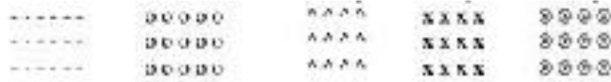
- Describe, in your own words, why you are seeking treatment today:
  ____
  ____
- How long have you had this condition? ______________________________________
- What makes your current condition feel better? ________________________________
  - What makes it feel worse? ____
- Have you been given a medical diagnosis for this condition? If so, what is it?
  - ____
- What is your level of hopefulness that your current condition is going to improve?
  - **Circle one:** (Not at all hopeful) **0 1 2 3 4 5 6 7 8 9 10** (Very Confident)

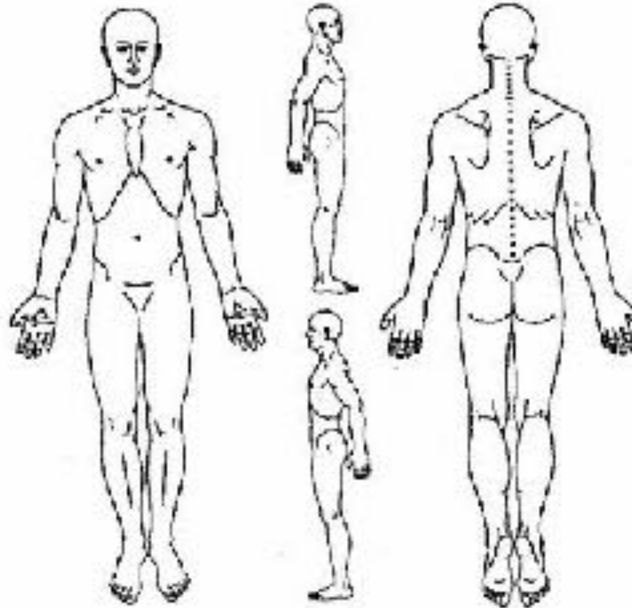
City Center Stage Door, 130 W 56th Street, FL 3, NY, NY 10019; 212.247.8436 (T) 877-839-2129 (F)
www.MahattanPhysioGroup.com

- **Pain Diagram** - Please mark your areas of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing

Additional Comments:





Previous Treatment for

Your Current Condition

- Have you had any previous treatment for the condition you are here for today? **Yes / No**
- If Yes, Please explain: ____

____

____

General Health

- Do you feel fatigued or often find it difficult to get through a day due to low energy levels? **Yes / No**
- Are you sensitive to pressure on your muscles, or find that you are easily irritated or inflamed? **Yes / No**
- Do you smoke?
  - **Yes / No** - If Yes, how much per day? ___________ Per week? ___________
- Do you drink alcohol?
  - **Yes / No** - How many drinks per day? ___________ Per week? ___________

Personal and Family Health History

Please indicate if you or a close family member suffer from any of the following:

- **Chest pain** - Me ❒ or Family Member __________________________________
- **Diabetes** - Me ❒ or Family Member ____________________________________

- **High blood pressure** - Me ❒ or Family Member ______________________________
- **Irregular heartbeat** - Me ❒ or Family Member ________________________________
- **Irritable Bowel** - Me ❒ or Family Member ___________________________________
- **Rheumatoid Arthritis** - Me ❒ or Family Member ______________________________
- **Osteoarthritis** - Me ❒ or Family Member ____________________________________
- **Shortness of breath** - Me ❒ or Family Member _______________________________
- **Dizziness or fainting** - Me ❒ or Family Member ______________________________
- **Neurological Disorders** (Stroke, Multiple Sclerosis, Alzheimer's, Parkinson's Dz, etc.)
  - Me ❒ or Family Member ____
- **Other not listed** - Me ❒ or Family Member __________________________________
- **Pregnancy** – Dates and type of delivery: ____

Exercise

- How many days / week, on average, do you exercise aerobically for 30 minutes? _______
- Do you do any strength training? **Yes / No** Balance training? **Yes / No**
- What else do you like to do to stay active? _______________________________________
- ____

Diet

- Are you vegetarian or vegan? **Yes / No**
- What are the 3 worst foods you eat each week? The 3 best? ________________________
- How much water do you drink each day? _________________________
- What % of your food intake is home cooked? ______________________
- Do you take any vitamins or supplements? (which ones and why)
  - **Yes / No** ____

Medications: Please list any medications you take, when you started taking them, and why.

- Medication: _____________________ Since: ________________ For: __________________
- Medication: _____________________ Since: ________________ For: __________________
- Medication: _____________________ Since: ________________ For: __________________
- Medication: _____________________ Since: ________________ For: __________________

Sleep Hygiene

- How many hours of sleep do you get on an average night? _________________________
- What time do you typically go to bed and wake up? ________________________________
- Does that sleep schedule change from day to day in an average week? ______________
- Do you feel well rested in the morning? **Yes / No**

- Is there anything that routinely interferes with you staying asleep? (pain, going to the bathroom, other) ____
-

Interpersonal Communication and Mood

- Do you feel that you can discuss important things with the people in your life?
  - **Yes / No**
- Rate your happiness on a scale from 1 (very unhappy) to 100 (very happy)
  - ____
- Would you consider your mood to be depressed? **Yes / No**
  - Does this vary depending on the season? **Yes / No**
- Do you struggle with anxiety that impacts your daily life? **Yes / No**
  - How does it affect you? ____
  - ____

Stress and Stress Management

- On a scale from 0 (no stress) to 100 (maximum stress), how would you rate your stress levels on an average work day ___________________?
  - On an average non-work day _______________?
- Have you had a period of high stress levels that went on for greater than 6 months?
  - **Yes / No -** If yes, please explain. ____
- Please indicate what you do to keep your stress levels to a minimum, or manage periods of high stress: ____

Release for Communication Between Professions:

Manhattan Physio Group is an interdisciplinary practice, and our practitioners often seek the input of their colleagues from other disciplines within the practice to provide the highest quality care, but we would never have those conversations without your permission. Please sign below if you approve of your practitioners sharing clinical aspects of your case in order to offer the most well-informed and best possible treatment.

Print: __________________________ Sign: _________________________ Date:

HOLISTIC ATHLETE NYC / ANNA ESZTER HAJOSI, L.AC
FINANCIAL POLICY STATEMENT

INSURANCE:

I understand that billing of my insurance is done as a convenience to me. I understand that Holistic Athlete NYC has verified my insurance information, however verification of eligibility and/or benefit information is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility, any claims received during the interim period and the terms of the member's certificate of coverage applicable on the date services were rendered.

I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR ANY CHARGES FOR SERVICES PROVIDED TO ME. I am responsible for co-payments, co-insurances and deductibles I may have at the time of service. These will be collected accordingly each visit. Insurance companies deny claims for a variety of reasons. If this occurs, the unpaid balance on my account is due and payable immediately. I understand that Holistic Athlete NYC will not become involved in any kind of dispute between me and my insurance company regarding uncovered charges, pre-existing conditions, coordination of benefits, eligibility issues or any other matter, which causes the claim to be denied.

I ___________________________________authorize the release of any medical or other information necessary to process my claims. I also authorize payment of government benefits either to myself or to the party who accepts assignment in box of 27 of the CMS 1500 form on which claims for me are submitted.

INSURANCE INFORMATION:

Name on card: _____________________________________

Date of birth: ______________________________________

ID number: ____

Group number: _____________________________________

24 HOUR CANCELLATION POLICY:

If I need to cancel my scheduled appointment, I will notify Holistic Athlete NYC as soon as possible, at the very last, **24 hours** before my scheduled appointment. If I have to cancel an appointment with less than 24 hours notice my account will be charged **FULL AMOUNT** for the visit. Such charges will be my responsibility, since they will not be covered by any insurance.

Patient's responsibility:
Copay / Coinsurance:
Deductible:
Visit limit:

Signature: ____Date: _________________

ACUPUNCTURE INFORMED CONSENT TO TREAT
HOLISTIC ATHLETE NYC / ANNA ESZTER HAJOSI, L.AC

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated above and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named above, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue.

I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

HIPAA: I ______________________________________ hereby authorize my Primary Care Physician or other specialist to release my medical records and health information regarding my care and treatment to Anna Eszter Hajosi, L.Ac with my medical information related as appropriate to assist with the acupuncture treatment. I understand the clinical and administrative staff may review my patient and lab reports, but all my records will be kept confidential. This release of information will remain in effect until terminated by me in writing. I also authorize Anna Eszter Hajosi, L.Ac to disclose my medical records to my insurance company for purposes of assisting with the settlement of my insurance claims for acupuncture. Anna Eszter Hajosi, L.Ac follows HIPAA regulations. The complete HIPAA privacy practices form is located in the office and I can request a copy at any time.

I understand that the practice of herbs/herbology is unregulated in NYS and that Anna Eszter Hajosi, is a NYS licensed acupuncturist. As such, I understand that NYS has made no determination regarding her competence to practice herbology or any other modality beyond those set forth in the definition of the practice of acupuncture in NYS law.

By voluntarily signing below, I show that I have read or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature: ____ Date: _________________

CREDIT CARD AUTHORIZATION FORM

I ____ authorize Anna Eszter Hajosi, L.Ac to charge my credit card for any late cancellations or missed appointments.

Credit card number: ____

Expiration date: ____

Zip code: ____

Security code: ____

Anna Eszter Hajosi, L.Ac agrees to notify me before charging the credit card above.

Date: ____

Signature: _______________________________________

Holistic Athlete NYC

Anna Eszter Hajosi, L.Ac. 4839

ALL INFORMATION PROVIDED ON THIS FORM IS CONFIDENTIAL

DATE: ____________________

PATIENT INFORMATION

Name: ____

Date of Birth: ____

Home Address: ____ Apt: __________________________

City: ____ Zipcode: __________________________

Phone: ____

Email: ____

Occupation: ____

Blue Cross Blue Shield out of network agreement

Anna Eszter Hajosi, L.Ac is out of network with Blue Cross Blue Shield.
This means that the insurance company sends the patient (you) the checks for all acupuncture services received.

When you receive the checks please either bring them in on your next visit or forward the checks to:

Holistic Athlete NYC
Anna Eszter Hajosi, L.Ac
130 West 56th Street FL 3
10019, New York, NY

Should you fail to reimburse the amount BCBS pays you in a timely manner (within two weeks after receiving the checks) we will automatically charge your credit card.

Date: ____

Signature: _______________________________________