



1787 Middle Ctry Rd.  
Centereach, NY 11720  
(631) 467-3381

<http://sttereizaptandrehab.com/>

Dr. Malak Azab, PT, DPT, TPI CGFI, CKTP  
Doctor of Physical Therapy

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We are Physical Therapy Experts and our secrets of pain relief are very effective. Our skilled, caring staff provides excellent care in a healing environment maintaining high standards of professional and personal attention.

We get people better fast! Through manual therapy techniques and cutting-edge functional exercises our physical therapy delivers. Our approach is simple: provide top-notch, individualized care in a fun, friendly, dynamic environment.

We are different because we provide hands-on physical therapy. Our patients receive their manual therapy by a doctor of physical therapy. At St. Tereiza Physical Therapy you see the same doctor of physical therapy every time you walk in the door. Dr. Malak will emphasize functional training to get you back to your every-day activities and athletic endeavors.

We help our patients achieve the highest level of functional independence by improving strength, mobility, balance and coordination. This is accomplished through pain reduction, disability reductions, and function restoration. We care intensely about what we do and what you need. We remove barriers that prevent you from enjoying the basic activities of life.

We are committed to providing convenient high quality, one-on-one physical therapy care in a friendly and caring atmosphere. Our philosophy is to integrate education and exercise in the treatment of the “whole” person. We expect patients to actively participate in their rehabilitation. Our goal is for patients to understand the mechanism of injury, how to facilitate an optimal and speedy recovery, and how to prevent the recurrence of injury. After your evaluation we will send a detailed report stating our findings and our treatment plan to your doctor.

It is important to follow your doctor and PT treatment plan if given a home exercise program. You must attempt to do this as this will shorten your therapy treatment and improve your progress. If your prescription says 3x a week, you should come 3x a week. Again, this will help reach your maximum potential.

Co-pay must be paid at every visit. Again, if your treatment calls for 3x a week you should come 3x a week. If you can not afford the 3<sup>rd</sup> co-pay or any co-pay please speak to the receptionist/therapist and we will try to make other arrangements. You should never allow a co-payment to compromise your health. Again, if there is a financial reason, talk to someone.

If you have any problems, complaints, or suggestions please do not hesitate to speak with me, Dr. Malak Azab, PT, DPT or one of my receptionists at 631-467-3381.

Thank you,

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## **NOTICE OF PATIENT INFORMATION PRACTICES**

This notice describes how medical information about you may be used or disclosed and how you can get access to information, please review it carefully. If you have any questions about this policy you may contact our office.

### **ST. TEREIZA PHYSICAL THERAPY'S LEGAL DUTY**

It is the legal duty of St. Tereiza Physical Therapy to protect the confidentiality of your personal health information. We are required to provide you with this notice which outlines our policies and procedures.

### **USES AND DISCLOSURES OF HEALTH INFORMATION**

*St. Tereiza Physical Therapy*, hereafter referred to as the Practice, uses your personal health information (PHI) in order to provide treatment to you, to be able to obtain payment for your treatment, to perform administrative activities within the practice, and for being able to determine the quality of care that is provided to you. PHI is all the personal information that can identify you: your name, address, telephone number, social security number, health policy number, etc. For example, we may use your PHI to call you about an appointment or to contact your insurance company for payment, speak to your Doctor about your program, or just call you into the treatment area from the waiting room.

The Practice may use your PHI without prior authorization when we are required to do so by law, if there is a public health concern, if you have a communicable disease, if we believe that there is abuse or neglect, for research studies, for legal proceedings, for law enforcement, if a crime occurs in the Practice's office, if an emergency occurs, to funeral directors and coroners, for military activity and national security, and for worker's compensation.

It is policy of St. Tereiza Physical Therapy to get a signed authorization from you prior to releasing your PHI. You have the right to either agree or object to the release information. If you agree and sign a written authorization, you have the right to take back the authorization at a later date if you choose to. If you are not actually present, or unable to agree or disagree to the disclosure of information, the Practice can then use its professional judgment to decide if the disclosure is in your best interest.

### **PATIENT'S INDIVIDUAL RIGHTS**

You have the right to inspect and ask for a copy of your personal health information at any time. You have the right to ask us to make changes or corrections in your information. The Practice does not have to comply with your request. You have the right to file a disagreement with the Privacy Officer.

You may request a list of all the disclosures that we have made of your PHI for any reason other than for treatment, billing, or administrative activities of the practice.

You also have the right to ask in writing that the Practice not disclose your PHI except when authorized by you, required by law or in the case of an emergency. You may also request that your PHI is not disclosed to family members or friends that may be involved in your care. The Practice will consider all such requests, but it is not required to agree or act on them. You have the right to have confidential information sent to you at an alternative location or by a means other than the postal service.

You have the right to obtain a copy of this notice.

### **CONCERNS AND COMPLAINTS**

If you feel that your privacy rights have been violated at any time or you do not agree with how your PHI is being disclosed, you can contact our Practice. We will not retaliate against you for filing a complaint. You can also contact the Secretary of Health and Human Services.

The terms of this notice may change at any time. A copy of the revised notice will be posted in the office in easily accessible areas and will be provided to you upon your request.



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**PATIENT ACKNOWLEDGEMENT OF  
RECIPT OF PRIVACY PRACTICES NOTICE**

This is to acknowledge that I have received and reviewed St. Tereiza Physical Therapy's Notice of Privacy Practices. If I have any questions, I can contact St. Tereiza Physical Therapy at (631) 467-3381.

**PRINT NAME:** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_



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PATIENT INFORMATION	EMAIL ADDRESS
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First Name:	Last Name:	Mid Init.	Date:
Address:		City:	State: Zip:
Birth date:	Age:	<input type="radio"/> Male <input type="radio"/> Female	S.S.#:
Home Phone:	Cell Phone:	*Cell Carrier:	Spouse:
Chose Clinic because/referred to clinic by: <input type="radio"/> Dr. _____ <input type="radio"/> Insurance Plan <input type="radio"/> Family <input type="radio"/> Friend <input type="radio"/> Former Patient <input type="radio"/> Close to work/home <input type="radio"/> Website <input type="radio"/> Yellow Pages <input type="radio"/> Street Sign <input type="radio"/> Brochure <input type="radio"/> Other:			

WORK INFORMATION
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Employer:	Work Phone:	Ext.
Occupation:	Employment Status <input type="radio"/> Full Time <input type="radio"/> Part Time <input type="radio"/> Retired <input type="radio"/> Not employed	

CARE PROVIDER INFORMATION
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Referring Dr:	Referring Dr. Phone:
Regular Dr./PCP	Regular Dr./PCP Phone:

INSURANCE INFORMATION	(PLEASE GIVE YOUR INSURANCE CARE TO RECEPTIONIST)
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Primary Insurance Name:		
Subscriber's Name (if different)	Birth date:	
ID. #:	Group/Policy #	S.S.#:
Patient's Relationship to Subscriber: <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other:		
Name of Secondary Insurance:		
Subscriber's Name:		Birth date:
ID. #:	Group/Policy #	S.S.#:
Patient's Relationship to Subscriber: <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other:		

AUTO OR WORK INJURY CLAIM	(PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)
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Insurance Name: <input type="radio"/> Auto: <input type="radio"/> Labor & Industries			
Adjuster/Claim Manager:		Phone:	Ext.:
Address:		City:	State: Zip:
Claim #:	Accident Date:	Cause:	

ATTORNEY INFORMATION
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Name:	Law Firm:	Phone:
Address:		City: State: Zip:

IN CASE OF EMERGENCY
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Name of Local Friend or Relative (not living at same address):		
Relationship to patient:	Home Phone:	Work Phone:

I authorize my insurance benefits be paid directly to St. Tereiza Physical Therapy. I understand that I am financially responsible for any balance. I also authorize St. Tereiza Physical Therapy to release any information required to process my claims.

\_\_\_\_\_  
PATIENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

**Initial Questionnaire**



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

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

In order to allow the therapist to have a better understanding of the nature of your injury and evaluate your condition fully, please complete the following questions as accurately as possible. Thank you.

1. Briefly describe how your symptoms began or how your injury occurred? \_\_\_\_\_  
\_\_\_\_\_

2. When did your symptoms start? \_\_\_\_\_

3. What are your symptoms (i.e./ pain, numbness, tingling)? \_\_\_\_\_  
\_\_\_\_\_

4. Where are your symptoms? Please mark on the diagram at the right.

5. The onset of my symptoms  Gradual  Sudden

6. Date of first doctor's appointment for this injury or for these symptoms was \_\_\_\_\_

7. My symptoms have  
 worsened  remained the same  improved

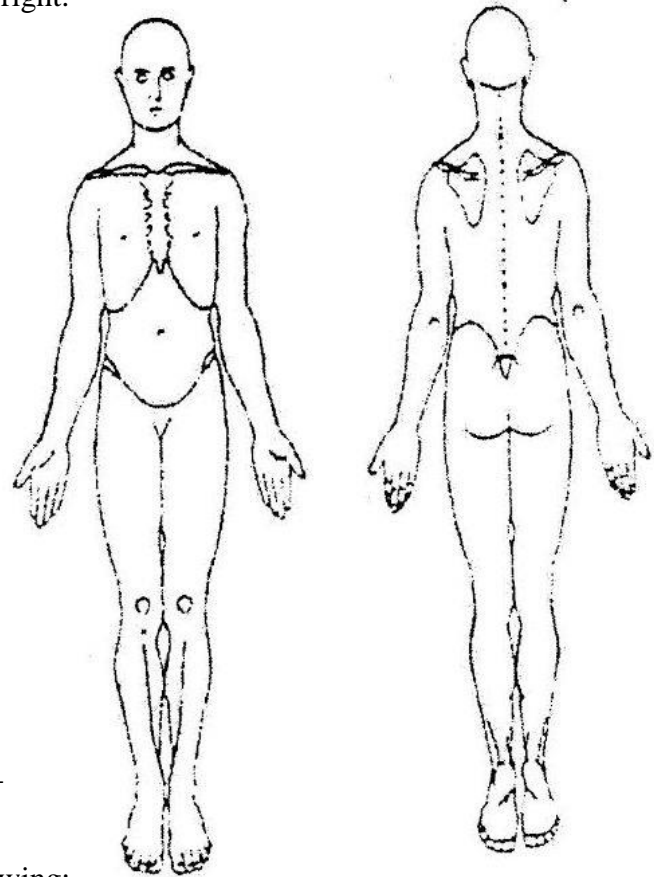
8. My pain over the last few days has been (0-10) \_\_\_\_\_

9. My symptoms bother me  
 constantly  most of time  occasionally

10. Type of pain?  
 Sharp  Dull  Throb  Ache  Burning

11. What makes your symptoms worse? \_\_\_\_\_  
\_\_\_\_\_

12. What makes your symptoms better? \_\_\_\_\_  
\_\_\_\_\_



13. Since the onset of the injury, have you noticed any of the following:  
A. Regular numbness or tingling  Yes  No If yes, where? \_\_\_\_\_

B. Bowel/bladder control difficulties  Yes  No

14. Have you had imaging of your injury?  Yes  No If yes, when did you have your imaging? \_\_\_\_\_  
 Xray  MRI  Bone Scan  CT Scan  Ultrasound  
What were the results? \_\_\_\_\_

15. Have you had this pain/problem before?  Yes  No  
If yes: A) Did you get treatment?  Yes  No If yes, did the treatment help? \_\_\_\_\_  
B) What did the treatment consist of? \_\_\_\_\_

16. What are your goals for physical therapy? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

17. Is there anything else about you or your condition that you would like us to know? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

18. Medical History

Please list any surgeries or injuries, for which you have been treated, including fractures, dislocations, sprains.

		DATE
<input type="checkbox"/> Surgery	<input type="checkbox"/> Injury _____	_____
<input type="checkbox"/> Surgery	<input type="checkbox"/> Injury _____	_____
<input type="checkbox"/> Surgery	<input type="checkbox"/> Injury _____	_____

Please review the following conditions. Do you now have/ever have been diagnosed with any of the following?

ASTHMA	Y/N	EMPHYSEMA	Y/N	SENSITIVITY TO HEAT/COLD	Y/N
CANCER _____	Y/N	OTHER LUNG PROBLEMS	Y/N	TUBERCULOSIS	Y/N
DIABETES	Y/N	HIV/AIDS	Y/N	OSTEOPOROSIS	Y/N
RHEUMATOID		SEVERE/FREQUENT		SEIZURE DISORDER	Y/N
ARTHRITIS/LUPUS	Y/N	HEADACHES	Y/N		
OSTEO ARTHRITIS	Y/N	THYROID PROBLEMS	Y/N	HERNIA	Y/N
HEART PROBLEMS	Y/N	KIDNEY PROBLEMS	Y/N	STROKE	Y/N
HIGH BLOOD PRESSURE	Y/N	LIVER PROBLEMS	Y/N	ANEMIA	Y/N
HEAD INJURY	Y/N	HEPATITIS _____	Y/N	PACEMAKER	Y/N
ALLERGIES _____	Y/N	MULTIPLE SCLEROSIS	Y/N	INCONTINENCE	Y/N

Have you recently noticed any of the following?

WEIGHT GAIN/LOSS	Y/N	FATIGUE	Y/N	DIZZINESS	Y/N
NAUSEA/VOMITTING	Y/N	WEAKNESS	Y/N	FEVER/CHILLS/SWEATS	Y/N
NIGHT PAIN	Y/N				

Are you pregnant? Yes No      If yes, what is your expected due date? \_\_\_\_\_

**MEDICATIONS**

Circle any OVER-THE-COUNTER medications you have taken in the last week.

- Aspirin
- Tylenol
- Advil/Motrin/Ibuprofen/Alieve
- Laxatives
- Decongestants
- Antihistamines
- Antacids
- Vitamins/Mineral Substances

Please list any PRESCRIPTION medication you are currently taking (including pills, injections, and/or skin patches) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What do you do for recreation? \_\_\_\_\_

What is your mode of exercise? \_\_\_\_\_

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

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



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## **NEWSLETTER OPT-IN AGREEMENT**

Thank you for choosing St. Tereiza Physical Therapy. We have created a unique newsletter for you. Each month you will be provided valuable information about services, injury & rehabilitation, and the latest on fitness and personal training.

We will include information about special programs, giveaways, and downloads. Learn about treatments, medical conditions, sports training, fitness, training techniques and more.

Information: **Please Print Clearly!**

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

**E-mail Address:** \_\_\_\_\_

By submitting this information, I confirm that I am only acting for my own e-mail account, or one for which I have express authority to submit this request. Once the subscription is confirmed, I agree to accept newsletter e-mails from St. Tereiza Physical Therapy and my e-mail address will not be used for any other purpose. I understand that I may unsubscribe at any time by following your instructions and that I may still receive a limited number of e-mails while this request is processed.

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

***ST. TEREIZA PHYSICAL THERAPY WILL NOT SHARE, DISTRIBUTE, OR  
SELL YOUR E-MAIL ADDRESS.***



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## **TO OUR PATIENTS REGARDING CANCELLATIONS AND NO-SHOWS**

The following are our policies regarding cancellations and no-shows. We take this subject seriously at the clinic because it can make the difference between whether you succeed in your treatment or not. Usually your referring doctor and/or your therapist have prescribed a set frequency of treatment. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow your therapist's instructions and we will be able to help you achieve your goals in treatment.

- We require 24 hours notice in the event of a cancellation. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get in the full prescribed number of treatments that week whenever possible.
- There is a \$25.00 charge for a cancellation without proper notice. This charge will not be covered by insurance but will have to be paid by you personally.
- For Worker's Compensation and Personal Injury patients documentation of any missed appointments is forwarded to your case manager and primary physician and this could jeopardize your claim.
- Please understand that your pain will probably increase and decrease as your course of treatment progresses and before it is finally erased. Either condition can seem to be a reason not to come in: a) You're feeling worse and think the treatment is not working or, b) you're feeling better and it's a great day for the beach. Neither of these conditions is legitimate as a reason not to come: a) if you're in pain, come in and get it fixed, b) if you're out of pain, now is the time that we can begin doing some real correction of the underlying causes of your problem, educate you so you won't reinjure yourself, etc.

When you don't show as scheduled, three people are hurt: You because you don't get the treatment you need as prescribed by the doctor and/or PT; the therapist who now has a space in their schedule since the time was reserved for you personally; and another patient who could have been scheduled for treatment if you had given proper notice.

Please co-operate with us in this regard. We're looking forward to working with you.

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Patient Signature

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Date





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## WORKERS COMPENSATION TERMS AND CONDITIONS FOR PHYSICAL THERAPY

I understand that my Workers Compensation Insurance will be billed at the Workers Compensation prevailing rate. However, if my Workers Compensation benefits are denied I understand that I will be responsible for your private fee. I also understand that I cannot be under the care of a chiropractor OR massage therapist while undergoing physical therapy or I am responsible for services rendered since Workers Compensation considers this concurrent treatment and will not pay.

Any insurance checks issued and sent to patient for physical therapy services will be signed over to St. Tereiza Physical Therapy. ***If insurance benefits are denied or if there is a deductible on your policy, patients are responsible for payment of services*** (major medical insurance may be used if Workers Compensation denies).

Payment is to be made to this office: St. Tereiza Physical Therapy.

I assign all benefits to Dr. Malak Azab/St. Tereiza Physical Therapy, if any, otherwise payable to me for all services rendered. I understand that I am financially responsible for all charges incurred whether or not paid by my insurance company, including deductibles and co-payments. Interest of 1.5% per month (18% annually) will be charges to overdue accounts. I hereby authorize the release of all information necessary to secure payment benefits. Any collection costs (including attorney fees) will be charged to delinquent accounts, and may be reported to credit rating agencies. I realize that insurance assignment is a courtesy extended by St. Tereiza Physical Therapy PC and that I am ultimately responsible for payment of all services rendered if the insurance company denies payment for any reason to this office.

If I am unable to keep my appointment, I will give the office a 24 hour cancellation notice. If 24 hour notice of cancellation is not given, the regular fee will be charged.

I have read the above, and agree to the terms and conditions.

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



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## WORKER'S COMPENSATION QUESTIONNAIRE

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

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

Telephone: \_\_\_\_\_ SS#: \_\_\_\_\_

### EMPLOYER INFORMATION (At time of accident)

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

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

Employer Telephone: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Occupation: \_\_\_\_\_ Are you currently working?: \_\_\_\_\_

If no, when was the last day you worked?: \_\_\_\_\_ When did you return to work? \_\_\_\_\_

### WORKER'S COMPENSATION CARRIER

Name of Worker's Compensation Insurance Carrier: \_\_\_\_\_

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

Adjuster: \_\_\_\_\_ Carrier/Adjuster Telephone: \_\_\_\_\_

Carrier Case #: \_\_\_\_\_ WCB#: \_\_\_\_\_

### INJURY INFORMATION

Date of injury: \_\_\_\_\_ Time of injury: \_\_\_\_\_ Address of injury: \_\_\_\_\_

What injuries did you suffer: \_\_\_\_\_

How did accident happen?: \_\_\_\_\_

Have you received any treatments prior to visiting this office? \_\_\_\_\_

What kind of treatment? \_\_\_\_\_ Were x-rays taken? \_\_\_\_\_

When was your first exam? \_\_\_\_\_ Who examined you? \_\_\_\_\_

Have you ever had a Worker's Compensation claim before? \_\_\_\_\_

Is your case currently controverted? \_\_\_\_\_ Date of next hearing: \_\_\_\_\_

Attorney Name: \_\_\_\_\_ Attorney Telephone: \_\_\_\_\_

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

I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible in the event that my Worker's Compensation benefit is denied. I also authorize St. Tereiza Physical Therapy PC to bill my private health insurance coverage in the event my Worker's Compensation claim is denied or controverted.

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

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