Patient Demographic Form

Please Fill Out Completely

PATIENT INFORMATION

First Name | **Last Name** | **Middle Initial** | **Preferred Name**

Date of Birth | **Social Security #** | **Gender**

Home Address | **City** | **State** | **Zip Code**

Home Phone | **Cell Phone** | **Email Address**

Employer | **Employer Phone Number**

EMERGENCY CONTACT INFORMATION

First Name | **Last Name** | **Relationship to Patient**

Home Phone | **Cell Phone**

PHYSICIAN REFERRAL INFORMATION

Referring Physician

How did you hear about us?

- ☐ Friend
- ☐ Employer
- ☐ Family Member
- ☐ Insurance
- ☐ Physician
- ☐ Website
- ☐ Other

INSURANCE INFORMATION

Were you injured at work or a car accident? ☐ Yes (If so, skip to Worker's Comp/No Fault) ☐ No

Primary Insurance Carrier | **Insurance ID #**

Guarantor First Name | **Guarantor Last Name** | **Group #**

WORKER'S COMP/NO FAULT INFORMATION

Insurance Carrier | **Date of Accident**

Claim # | **WCB #** (Worker's Compensation only)

Adjuster's Name | **Phone Number** | **Email Address**

PATIENT'S AUTHORIZATION TO RELEASE MEDICAL INFORMATION

The information above is true and accurate to the best of my knowledge. I hereby authorize Elite Physical Therapy P.C. to release any information acquired in the course of treatment for the purpose of claim filling. A Photostat of this authorization shall be considered as effective and as valid as the original.

Patient Signature | **Date**

PATIENT'S AUTHORIZATION TO RELEASE CLAIM PAYMENT

I hereby authorize and direct my insurer to issue payments for benefits due to me directly to Elite Physical Therapy P.C. Regardless of my insurance benefits, if any, I understand that I am financially responsible for all services rendered.

Patient Signature | **Date**

Patient Medical Intake Form

Please Fill Out Completely

MEDICAL HISTORY

Surgical Procedures	Date	Hospitalizations	Date

Do you smoke? ☐ No ☐ Yes. If so, how many packs per day?

Are you allergic to any medications?

Please list all medications you are presently taking

HISTORY OF INJURY

Were you injured at work or a car accident? ☐ Yes ☐ No

Briefly describe your problem

Approximately, when did your condition start?

Surgery Date (if applicable)

Nature of Pain:

- ☐ Sharp
- ☐ Dull/Achy
- ☐ Throbbing
- ☐ Numbness
- ☐ Shooting
- ☐ Burning
- ☐ Tingling

How often do you have pain?

- ☐ Constant (76% - 100%)
- ☐ Frequent (51% - 75%)
- ☐ Occasional (26% - 50%)
- ☐ Intermittent (25% or less)

Symptoms are worse in

- ☐ Morning
- ☐ Afternoon
- ☐ Night
- ☐ Increased during the day

Did you have any diagnostic imaging for this condition?

Type of Imaging/Body Part	Date	Type of Imaging/Body Part	Date

Occupation

Has your work status changed due to this condition? ☐ Yes ☐ No

TREATMENT HISTORY

Have you <u>ever</u> been treated by a Physical Therapist/Chiropractor? ☐ Yes ☐ No

What were you treated for?

Have you done physical therapy this calendar year? (check box that applies)

☐ **NO**, I have not been treated at any other physical therapy facility **<u>this</u>** calendar year. I have not used up any of my physical therapy visits allowed by my health plan.

☐ **YES**, I have been treated another physical therapy facility **<u>this</u>** calendar year. I have used _____ visits from my physical therapy limits allowed by my health plan.

PATIENT ATTESTATION

I have provided all of the above information to the best of my knowledge at the time of this visit and will notify this office if any information has changed during my care at Elite Physical Therapy P.C.

Patient Signature **Date**

Explanation of Procedures

Please Read Carefully

Welcome to our practice. You are here because you have been referred to us by your doctor for physical therapy. Physical Therapy is defined as: "The evaluation, treatment or prevention of disability, injury, disease, or other condition of health using physical, chemical and mechanical means including, but not limited to heat, cold, light, air, water, sound, electricity, massage, mobilization and therapeutic exercise…"

Here is the explanation of some of the Physical Therapy procedures and modalities that you may receive during your course of treatment with us. Please make sure that if you have any questions you ask your Physical Therapist to answer them to your satisfaction.

Therapeutic Exercise (97110): These are exercise that help to improve Range of Motion and/or Muscle Strength and/or Endurance and may include activities using equipment such as a bicycle, a treadmill etc.

Neuromuscular Re-education (97112): There are therapeutic procedures that help to improve balance, coordination, and proprioception. We use techniques called PNF, Proprioceptive Training, BAP's boards etc.

Manual Therapy (97140): These are skilled manual therapy techniques and include Trigger Point Therapy, Mobilization Techniques etc.

Kinetic Activities (97530): These procedures involve using functional activities such as bending, lifting, carrying, reaching, etc. and have as a goal to improve your functional performance in a progressive manner.

Electrical Stimulation (97014) & Ultrasound (97035): These are physical agents, used in conjunction with the other treatments to reduce pain, inflammation etc.

PATIENT ATTESTATION

By signing this document, I acknowledge that I understand that I may receive a number of the above listed services and all of my questions were answered by the treating therapist to my satisfaction.

Patient Signature **Date**

American Physical Therapy Association. Guide to Physical Therapy Practice. Alexandria, VA: APTA; 1999
HCFA Medicare. Physical Medicine & Rehabilitation, Policy number (YPF#86), (YMed#09). MNB: Medicare: 1997
New York Physical Therapy Board Practice Act. Education Law Article 136; PTs and PTAs, 2000

Office Policy

Please Read Carefully

Welcome to our practice. Thank you for your confidence and trust in scheduling an appointment with our clinic. We are always dedicated to quality care for all our patients and we are always here to discuss your problems and concerns so that together we can find the most appropriate solution. Our office policy is as follows. Please read carefully and sign.

1. **In the event of a cancellation we require 24-hour notice.** It is your responsibility, whenever possible, when you call in, to have an alternate time in mind that will ensure you get in the full prescribed number of treatments that week.
2. **If there is a cancellation without proper notice you will be charged $20.00.** This charge **will not** be covered by your insurance company, but will have to be paid by you personally prior to your next treatment. You should understand that when you do not show up to a scheduled appointment, three people are affected: You as a patient because you do not receive the treatment prescribed to you by your physician and your therapist to get optimal results, the therapist who has reserved that time in their schedule for you personally, as well as another patient who could have been seen for treatment had you given us proper notice.
3. **Regarding Lateness:** if you are late, you may not get in your full treatment because it would mean other patients are delayed. Please call and notify the office of your lateness in order for us to try and best accommodate you when you do arrive.
4. **Regarding Being Early:** Most of the time you'll have to wait until your scheduled time to be seen because there are other patients who are still in treatment.
5. For your health's benefit we have developed both a formal evaluation process and a discharge process in which the treating therapist prepares a report for your doctor.
6. Please understand that your insurance policy is a contract between you and your insurance company. While we may accept your insurance as payment, your contract with us is a separate agreement. In other words, if your insurance refuses to cover a certain treatment or otherwise fails to pay us, your contract with us still exists, and you are personally responsible for payment.
7. Co-pays, deductibles, and payments if you are paying out of pocket are due **at the time of service.** We accept payments by cash, money order, or check.
8. We will allow, on special occasions, a long-term payment plan budgeted on the individual according to need. In any event, if you request such a plan, you will sign a written agreement which must be given final approval by the Clinical Director.
9. If at any point you have a problem regarding billing and payment, talk to our receptionist and they will arrange for you to see our office manager.

PATIENT ATTESTATION

By signing this document, I agree to be treated at Elite Physical Therapy P.C. by the physical therapists and their staff and I also agree with terms and conditions specified above.

Patient Signature **Date**