PATIENT / ACCOUNT INFORMATION

Check One: New Patient____ Change of Information Only____

PATIENT INFORMATION (PLEASE PRINT CLEARLY)

Patient Name:_______________________________ Date of Birth:___________________

Social Security #:__________________Sex:______Marital Status:__________________

Street Address:________________________________

City:_____________________________State:_____Zip Code:_______________________

Home Telephone #:__________________________

Cell Phone #:_______________________________

Email: ____________________________________

Referring Physician: _____________________________

If referred by someone other than physician, please specify: ________________________

Emergency Contact:_________________________Relationship:___________________

Emergency Telephone #:________________________

IF WORKERS COMPENSATION, FILL OUT BELOW:

Employer Name:___________________________Job Title:_________________________

Street Address:____________________________

City:___________________________State:____Zip Code:__________________________

Work Telephone#:_______________________Extension:______

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 (Parent/Guardian) 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 (Parent/Guardian) Signature:__________________________ Date:___________

Medical History

PLEASE LIST ANY MAJOR SURGERIES AND HOSPITALIZATIONS:

________________________ Date: _______________

________________________ Date: _______________

DO YOU SMOKE? Yes/ No If yes, how many packs per day? ________
ARE YOU ALLERGIC TO ANY MEDICATION? Yes/No If yes, please list medications:
____

PLEASE LIST ALL MEDICATIONS YOU ARE PRESENTLY TAKING

PLEASE MARK THE FOLLOWING IF ANY OF THESE DIAGNOSTIC TESTS HAVE BEEN DONE?

___ X-RAYS DATE:______ RESULTS:_____________________________
___ MRI DATE:______ RESULTS:_____________________________
___ EMG/NCV DATE:______ RESULTS:_____________________________

Is this, your problems, due to injury / Work related / A motor vehicle accident/ or other?

PLEASE DESCRIBE YOUR PROBLEM:

PLEASE CHECK THE FOLLOWING WHICH BEST DESCRIBES YOUR PAIN:

___ CONSTANT ___ INCREASING ___ NIGHT PAIN
___ INTERMITTENT ___ DECREASING ___ STIFFNESS
___ PAIN UPON WAKING ___ OCCASIONAL ___ STATIC
___ DULL/ ACHY ___ SHARP PAIN

PAIN IS AGGRAVATED BY: ____ PAIN
IS EASED BY: ____

Have you ever been treated by a Physical Therapist/ Chiropractor? Yes/No If
yes, approximate dates: ___________________

What were you treated for? ____

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, PC.

Signature of Patient : _____________________ Date: _____________

Elite Physical Therapy

Explanation of procedures

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.

<u>Therapeutic Exercise (97110):</u> 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.

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

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

<u>Kinetic Activities (97530):</u> 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.

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

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's Name	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

ELITE PHYSICAL THERAPY

Dear Patient,
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.

OFFICE POLICY

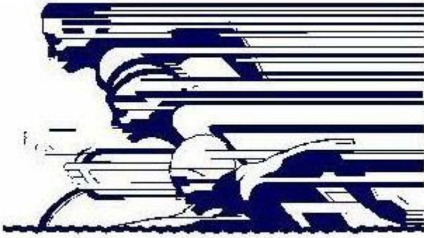
1. In the event of a cancellation we require 24-hour notice. It is your responsibility, whenever possible, when you call in, to have an alternate time in mind that will ensure you get in the full prescribed number of treatments that week.
2. **If there is a cancellation without proper notice you will be charged $40.00**. 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. **If you have 3 consecutive cancellations, you will be charged $25.00**. This charge **will not** be covered by your insurance company, but will have to be paid by you personally prior to your next treatment.
4. 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.

*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 she will arrange for you to see our office manager.

After you have read carefully the above, please sign the following:
I___________________________________agree to be treated in the therapy clinic by the therapists and their staff and I agree with terms specified above.

Patient Signature: _________________________ Date: ______________



Elite Physical Therapy

222-15 Northern Boulevard Bayside, NY 11361

23-09 31 Street Astoria, NY 11105

Insurance

___ I have NOT made any changes to my insurance plan. It is the same insurance plan as in 2018.

___ I have changed my insurance plan. My new insurance is ______________________.

History

___ I have NOT been treated at any other physical therapy facility this calendar year. I have not used up any of my physical therapy limits allowed by my health plan.

___ I have been treated at another physical therapy facility this calendar year.

I have used up ____ number of visits from my physical therapy limits allowed by my health plan.

Patient Signature ______________________

Date of signature ______________________