Physical Therapy & Beyond
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20 West Main Street, Suite 102, Riverhead, NY 11901 Phone (631) 941-3535 Fax (631) 941-3599
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PATIENT INFORMATION FORM

First Name: _____ Last Name: _____ Height: _____ Weight: _____

Marital Status: (circle one) Married / Single / Divorced / Widow / Widower Spouse/Partner's Name: _____

Birth Date: _____ Age: _____ Sex: M/F R/L Hand Dominant: _____ Shoe Size: _____

Home Address: _____ Home Phone: (_____)_____

City/State/Zip: _____ Cell Phone: (_____)_____

Work Phone: (_____)_____ E-mail: _____ What is the best way to contact you? _____

Employer Name / Work Address: _____

Current Work Status: (circle one) Full Time Part Time Retired Unemployed On Disability Restricted Work

Student Homemaker Not Working Due to Injury Occupation: _____

Is this condition due to: ____Auto Accident ____Workers Comp Injury ____Slip & Fall ____Other

If you have an attorney working with you, please provide their name & phone #:

_____

Have you received **physical therapy**, **occupational therapy**, **chiropractor**, and/or **speech therapy** since January 1st of this calendar year? Yes/No If yes, which therapy did you have and what were you being treated for? _____

_____

Whom may we thank for referring you? _____

What is the reason for today's visit? _____

_____

When is your next appointment with the doctor who is seeing you for this condition? _____

What are your ***goals*** you would like therapy to help you with? _____

_____

Please give a date this problem / accident / injury started: _____

Have you been treated for this condition before? Yes/No **Have you received homecare services of any kind?** Yes/No

Dates & Descriptions of Surgeries: _____

_____

Allergies: _____

If you are pregnant or previously pregnant: How many weeks: _____ Estimated due date: _____

High Risk: Y/N age / premature contractions / incompetent cervix / episodic bleeding / nausea / multiple pregnancy

Schedule C-Section Y/N? If yes, what is date of c-section: _____

How many pregnancies: _____ Natural/C-Section Episiotomy? Yes/No

# of living children: _____ Ages of children: _____, _____, _____, _____, _____, _____

Have you experienced any loss of urine following previous childbirth? Yes/No Or as a child? Yes/No

If applicable, when was onset of Menopause? _____

Have you been on Hormone Replacement Therapy? Yes/No Dosage: _____ Type: _____

Physical Therapy & Beyond

PATIENT INSURANCE, CANCELLATION POLICY AND HIPPA AUTHORIZATION FORM

Primary Insurance Carrier: _____ Self/Spouse: Name & DOB: _____

Secondary Insurance Carrier: _____ Self/Spouse: Name & DOB: _____

Tertiary Insurance Carrier: _____ Self/Spouse: Name & DOB: _____

If No-Fault or Workers Compensation: Insurance Company Name: _____

INSURANCE AUTHORIZATION SECTION:

Physical Therapy & Beyond strongly believes that patients should not pay for any services their insurance companies are obligated to cover. As a courtesy to our patients, we will bill your insurance company in an attempt to recover any payments due fully for the services provided. Any uncollected fees are billed to the patient only after all options to get paid for services have been exhausted by our Accounting Department. I understand that I am fully responsible for notifying Physical Therapy & Beyond of any changes regarding my medical coverage during ongoing treatment. The changes in medical coverage may include an auto accident, a work-related injury, termination of insurance or a change of insurance company and/or policies. ***If I do NOT comply with this policy, I understand and am fully aware I will be liable for any and all outstanding bills.*** I further understand that I am responsible for paying the balance of charges in the event my insurance does not fully cover for all services provided, including deductible, co-pay, co-insurance or percentage authorized or limited by law. Additionally, I hereby authorize and assign insurance benefits to Physical Therapy & Beyond and the release of any and all medical records as requested by any insurance company so that my bills can be processed and paid.

To Our Patient Regarding Cancellations and No-Shows

The following are our policies regarding cancellations and no-shows. We take this subject seriously because it can make the difference between whether you succeed in your treatment or not. Usually your referring doctor and/or your Physical 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 Physical Therapist's instructions and we will be able to help you achieve your goals in treatment**. We require 24-hour notice in the event of a cancellation.** When you call in, it is your responsibility to have an alternative date and time in mind. This will ensure that you get the full prescribed number of treatments for that week whenever possible. **There is a charge of $35 for a cancellation without proper notice. This charge will not be covered by insurance and must be paid by you personally.** Worker's Compensation and Personal Injury patients are hereby informed that documentation of any missed appointments is forwarded to the Case Manager and Primary Physician and could jeopardize your claim.

Patient Signature: _____ Date: _____

Acknowledge of Privacy Practice Notice: I have been offered a copy of the *Notice of Privacy Practices* from Physical Therapy & Beyond.

HIPPA RELEASE FORMS

I authorize Cindi A. Prentiss, P.T., P.C., and/or staff to release information to the following **physician(s)**:

1 - DOCTOR'S NAME & SPECIALTY: _____

2 - DOCTOR'S NAME & SPECIALTY: _____

I authorize Cindi A. Prentiss, P.T., P.C., and/or staff to discuss my healthcare with the following **person(s)**:

First & Last Name: _____ **Phone Number:** (_____)_____

First & Last Name: _____ **Phone Number:** (_____)_____

Patient Signature: _____ Date: _____

If a minor, (under 18 years old), I give permission to have my child treated at Physical Therapy & Beyond.

Parent Signature: _____ Date: _____