ISLANDSPORTS® PHYSICAL THERAPY

Patient Information

Patient Name: _____

DOB: _____ Male: ___ Female: ___ SS#: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Home Phone: _____ Can we leave a detailed message? Yes___ No __

Cell Phone: _____ Can we leave a detailed message? Yes ___ No __

Employer: _____ Occupation: _____

Work Address: _____ Phone#: _____

Have you been treated at a different Physical Therapy office this year?

Yes___ No___ N/A ___

If yes, how many visits have you used? _____

In case of emergency, who should be notified?

Name: _____ Phone#: _____ Relationship: _____

Who is the Insurance Policy holder?

Name: _____ Relationship to Patient: _____ DOB: _____

Referred by: (circle one)

Doctor Friend Relative Internet Sign Walk in Ins. Plan Patient

Workers Comp/No Fault patients please complete the back of this form

No Fault/Workers Comp Information:

Workers comp or No Fault Carrier: _____

DOA: _____ Case/Claim#: _____

Claim Examiner/Adjuster Name & Phone: _____

Attorney Name & Phone: _____

Patient Signature: _____ Date: _____

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PATIENT HEALTH QUESTIONNAIRE

Name _____ Date _____

1. Please describe your current complaint or limitation: _____

_____

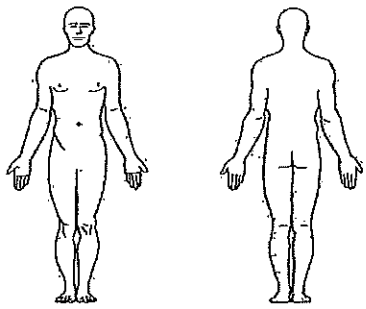
2. What is your goal for therapy: _____

_____

a. Please describe the nature of your pain:

O Sharp pain
O Dull (pain) ache
O Throbbing
O Numbness
O Shooting
O Burning
O Tingling

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



PLEASE CIRCLE INJURED AREA
UPON PRINTING

b. Indicate the intensity of your pain at rest: No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable pain

Indicate the intensity of your pain with movement: No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable pain

c. What movement causes the pain to increase: _____

d. Since this condition began your symptoms have: O decreased O not changed O increased

e. Your symptoms are worse in: O morning O afternoon O night O increased during day O same all day

3. When did your problem begin:_____days ago / months ago / years ago specific date _____

Describe how your problem began: _____

_____

Did you have surgery? O Yes O No Date of surgery _____

4. In the past have you been treated for the same problem? O Yes O No

5. What makes your problem better? O Nothing O Lying down O Standing O Sitting O Movement/Exercise O Inactivity

6. What makes your problem worse? O Nothing O Lying down O Standing O Sitting O Movement/Exercise O Inactivity

7. Occupation _____ O F/T O P/T

Has your work status changed because of this condition O Yes O No

8. What is your current work status? O FT, no restrictions O PT, no restrictions O Retired O Unemployed
O FT, with restrictions O PT, with restrictions O Full time student
O Full time homemaker O Off work due to restrictions

9. Medications? If yes, please list _____

10. Past or Present Medical History _____

Name: _____ Date: _____

In compliance with the Health Insurance Portability and Accountability Act (HIPPA) Privacy Rule and our Notice of Privacy Practices, Island Sports Physical Therapy will not disclose your Protected Health Information (PHI) without your explicit authorization, except as permitted by law for purposes of payment, treatment and health care operations. Furthermore, Island Sports Physical Therapy will limit the use, disclosure of and request for PHI to the minimum necessary to accomplish the intended purpose.

If you choose to have your PHI communicated to individuals other than yourself, please accurately complete the information below and sign the authorization.

I _____ the undersigned, herby authorize Island Sports Physical Therapy to disclose my PHI to the person(s) named below:

Name: _____ Relationship: _____ Phone#:_____

Name: _____ Relationship: _____ Phone#:_____

Name: _____ Relationship: _____ Phone#:_____

Signature: _____ Date: _____

ISLANDSPORTS®
PHYSICAL THERAPY

CANCELLATION AND NO-SHOW POLICY

Please inform us if you are unable to keep your appointment and give us **24 hours' notice, if possible.** We will try every effort to reschedule your appointment.

Please note: We request 24 hours' notice to cancel appointments for avoid out $25 cancellation fee.

3 No-Show appointments will result in discharge followed by notification to both your physician as well as your insurance carrier.

If you are late for your appointment your therapist will use judgment as to what is priority for treatment goals that session.

To receive the most benefit from your Physical Therapist, good attendance is essential. The staff at Island Sports Physical Therapy wants to give you the best possible service.

Patient Signature: _____ Date: _____

Date: _____

Patients & Friends,

Welcome to Island Sports Physical Therapy. The staff is pleased that you have chosen to rehab at one of our six facilities. We will make every effort to make your experience here both productive and pleasant. For you to achieve your therapeutic goals, it is important to understand what your patient responsibilities are. These policies are designed so that you receive the maximum benefit from each office visit.

- Schedule your weekly appointments at the frequency recommended by your therapist. If you must cancel, please give us 24 hours' notice, and be sure to reschedule within the same week.
- If you know that you are going to be late, please call the office, as we cannot guarantee that you will be treated. Your program may be modified in order to not compromise the treatment of other patients who are timely.
- Three No Show appointments will result in a discharge from your physical therapy program followed by a notification to you, your referring physician and your insurance carrier.

It is your responsibility to understand the limits of your insurance. We verified your benefits; however verification is not a guarantee of payment. Unless notified otherwise your financial responsibilities are limited to the following:

Co-payment $_____

Co-Insurance %_____

Deductible $_____

Max out of pocket $_____

You should contact your insurance carrier to confirm this information.

Patient name: _____ Patient Signature: _____

ISLANDSPORTS®
PHYSICAL THERAPY

Informed Consent

Conditions & Consent for Physical Therapy

I understand that I am a patient of Island Sports Physical Therapy, a private, therapist owned Physical Therapy Practice.

Cooperation with Treatment In order for Physical Therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances. I understand and agree to cooperate with and preform the home Physical Therapy program intended for me, if I have trouble with any part of my treatment program, I will discuss it with my Physical Therapist.

Cancellation Policy I understand that to successfully achieve the goals of treatment established by myself and my Physical Therapist it is essential for consistent attendance as outlined by my plan of care. I understand that three (3) no show could result in my discharge from Therapy. Furthermore, I understand that if I cancel 24 hours in advance, I will not be charged.

Limitations I understand that there are no guarantees regarding a cure for, or improvement in my condition. I understand that my Physical Therapist will outline and discuss goals for Physical Therapy treatment for my condition and treatment options with me before I consent to treatment. There may be times where my insurance company will withhold payment for certain services rendered, but care will be taken to inform me of such circumstances prior to rendered services.

Informed Consent for Treatment I understand the term "Informed Consent" means that the potential risks, benefits and alternatives of Physical Therapy treatment have been explained to me. The Therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

Financial and Insurance Responsibility I understand it is my responsibility to call my insurance company ahead of time to obtain any pre-authorization that is necessary, and to obtain verification of my outpatient Physical Therapy benefits. I understand Island Sports Physical therapy will call my insurance carrier as a courtesy for me but ultimately it is my responsibility to verify the information Island Sports Physical Therapy receives as accurate. If I have any questions regarding my insurance coverage I understand that I can ask my insurance carrier, my Therapist, or Island Sports Physical Therapy for further assistance.

Notice of Privacy Policy I understand that I was provided with a copy of the Notice of Privacy Policies utilized by Island Sports Physical Therapy in compliance with regulations under the Health Insurance Portability and Accountability Act (HIPPA) Sec. 45 CFR 160 and 164. I understand that if I would like more information about Island Sports Physical Therapy's privacy practices or to file a complaint, I can contact Island Sports Physiotherapy of East Northport, PC: Privacy officer at 3072 Jericho Turnpike. East Northport, NY 11731

I have read the above information and I consent to Physical Therapy evaluation and all subsequent treatment.

_____ _____

Print name Date

_____ _____

Patient/Guardian signature if patient is under 18 Witness