THERAPEUTIC SOLUTIONS PHYSICAL THERAPY

1757 Merrick Avenue, Suite 100
North Merrick, N.Y. 11566
Ph: (516) 623-4388 Fax: (516) 623-1948

Personal Information

Date _____
Name (Last, First) _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____

Date of Birth _____ Soc. Sec. Number _____
Gender: Male___ or Female ____ Full Time Student: Yes____ or No____
Marital Status: Single___ Married ___ Divorced ___ Separated ___ Widowed___
Domestic Partnership___

Name of Employer _____Employer Address _____
Work Phone _____ Ext _____ Occupation_____

Emergency Contact _____ Relationship _____
Emergency Contact Phone _____ Work Number _____
May we leave a message at your house?_____ With Whom _____
How did you find out about our office? _____
Prescribing/ Referring Doctor _____

E-Mail:_____

Insurance Information

Primary Insurance
Insurance Company _____
Phone_____
Policy/ ID # _____
Group # _____
Insured Name _____
Relationship to insured _____
Social Sec. ____-___-____DOB _____

Secondary Insurance
Insurance Company _____
Phone _____
Policy/ ID # _____
Group # _____
Insured Name _____
Relationship to insured _____
Social Sec. ____-___-_____ DOB_____ _____

*If you have a third insurance please notify us on your first visit.

This information I have given this office is complete and true to the best of my knowledge. I authorize the the staff of Therapeutic Solutions Physical Therapy to administer such procedures and treatment as they deem necessary. They have implied no guarantee of cure.

_____ _____
Signature of Patient or Personal Representative Date

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Individual Consent

CONSENT TO USE OR DISCLOSE YOUR HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

_____
PATIENT NAME

In providing service to you, we create and store health information that identifies you. We understand that this information is about you and your personal health, and we are committed to protecting the privacy of this information. We must obtain your *one time* consent before we treat you, obtain payment for our services, and conduct health care operations of the practice. Please read carefully the information below before signing this form.

Notice of Privacy Practices. We have a comprehensive Notice of Privacy Practice that describes these uses and disclosures in detail and we encourage you read it. We want you to know, however that the Notice of Privacy Practices is subject to change. If it is changed, you may obtain a copy of the revised notice by calling the office at (516) 623-4388, or asking for a copy at your next visit.

Revoking Consent. You have the right to revoke this consent at ant time, except to the extent that the center has already taken actions based upon your consent. For example, if you revoke your consent after the office has provided you with treatment, the office will be permitted to use or disclose your protected health information to bill for that treatment. To revoke this consent, please write to our office.

Scope of Consent. By signing this consent form, I herby authorize Therapeutic Solutions Physical Therapy and its providers to use and disclose my personal health information, as necessary, for the purposes of obtaining medical treatment, facilitating the payment for such treatment and for normal business operations.

_____ _____
Signature of Patient or Personal Representative **Date**

HIPAA PRIVACY NOTICE ACKNOWLEDGEMENT

By signing below, I acknowledge that I have been provided with an opportunity to read and receive a copy of the Notice of Privacy Practices and have therefore been advised of how certain health information about me may be used and disclosed by Therapeutic Solutions Physical Therapy and how I may obtain access to and control this information. If a breach or unauthorized disclosure occurs, I consent that I may be provided with notification of this via e-mail.

_____ _____
Patient Signature: **Date**

FOR PATIENTS ELECTING TO PAY PRIVATELY

I hereby instruct Therapeutic Solutions Physical Therapy to refrain from sending my protected health information (PHI) to payers (i.e Medicare, insurers) for services rendered that I have elected to pay privately for.

_____ _____
Patient Signature **Date**

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Office Policy

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive the maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our office payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. You can check with us for different forms of payment which are acceptable. We, as a courtesy to our patients, verify your insurance coverage for you. Although we would like to accept assignments from all carriers, you can check with us to see if we accept assignment under your situation.

If our office accepts assignment, we will file your insurance claims for you. You are responsible for paying all co-payments, co-insurance, deductibles or any non-covered services by means of payment we accept. We will gladly discuss your proposed treatment and answer any questions relating to your insurance. **If co-payments are not made at the time of service and we must bill you for a co-payment an additional $10 delinquency fee will be added to your outstanding co-payment.**

You must realize, however, that:

1) Your insurance is a contract between you, your employer, and the insurance carrier. We are not a party to that contract.
2) Our fees are generally considered to fall within the acceptable range by most carriers, and therefore are covered up to the maximum allowance determined by each carrier. This applies to carriers who pay a percentage of 50% to 80% of usual, customary, and reasonable charges for this region. Thus, our fees are considered usual, customary, and reasonable by most carriers. This does not apply to carriers who reimburse based on arbitrary schedule fees, which bears no relationship to the current standard and cost of care in this area.
3) Not all services are a covered benefit in all contracts. Some insurance carriers arbitrarily select certain services they will not cover.

Since our relationship is with you, not your insurance carrier, we strongly recommend you contact your insurance carrier to verify the coverage you have. Inaccurate information given to us by the insurance representative concerning your coverage is your responsibility.

While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the time services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account. Returned checks and balances over 30 days due may be subject to additional collection fees

If you have any questions about this information or uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us. We are here to help.

Prescriptions for Physical Therapy are good for one month, unless otherwise noted by the Physician. It is the patient's responsibility to obtain updated prescriptions from their doctor. In order for treatment to be continuous, we ask that the prescriptions be obtained in a timely manner. If said prescriptions are not updated, treatment cannot be rendered under New York State law.

Cancellation Policy

It is our mission to provide quality care for all of our patients in a timely manner. We respectfully request that you keep your scheduled appointment. If you need to re-schedule, please call us 24 hours in advance. **THERE WILL BE A $25.00 CHARGE COLLECTED IF YOU DO NOT SHOW TO YOUR APPOINTMENT without calling 24 hours in advance**.

I agree to comply with the office policy and the cancellation policy in event that I do not show up for my appointment without 24 hour notice.

Patient's Signature Date

Jamie Rockwin, P.T., DPT Date

Name:_____ **Date:** _____

Leisure activities, including exercise routines:_____

Occupation, including activities that comprise your workday:_____

Age: **Height:** **Weight:**
Are you on a work restriction from your doctor? Yes No **Are you latex sensitive? Yes No**
Do you smoke? Yes No **Do you have a pacemaker? Yes No**
FOR WOMEN: Are you currently pregnant or think you might be pregnant? Yes No
ALLERGIES: List any medication(s) you are allergic to: _____

Have you RECENTLY noted any of the following (check all that apply)?

- ❑ fatigue
- ❑ fever/chills/sweats
- ❑ nausea/vomiting
- ❑ weight loss/gain
- ❑ difficulty maintaining balance while walking
- ❑ falls
- ❑ numbness or tingling
- ❑ muscle weakness
- ❑ dizziness/lightheadedness
- ❑ heartburn/indigestion
- ❑ difficulty swallowing
- ❑ changes in bowel or bladder function
- ❑ constipation
- ❑ diarrhea
- ❑ shortness of breath
- ❑ fainting
- ❑ cough
- ❑ headaches

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ cancer
- ❑ heart problems
- ❑ chest pain/angina
- ❑ high blood pressure
- ❑ circulation problems
- ❑ blood clots
- ❑ stroke
- ❑ anemia
- ❑ bone or joint infection
- ❑ chemical dependency (i.e., alcoholism)
- ❑ depression
- ❑ lung problems
- ❑ tuberculosis
- ❑ asthma
- ❑ rheumatoid arthritis
- ❑ other arthritic condition
- ❑ bladder/urinary tract infection
- ❑ kidney problem/infection
- ❑ sexually transmitted disease/HIV
- ❑ pelvic inflammatory disease
- ❑ thyroid problems
- ❑ diabetes
- ❑ osteoporosis
- ❑ multiple sclerosis
- ❑ epilepsy
- ❑ eye problem/infection
- ❑ ulcers
- ❑ liver problems
- ❑ hepatitis
- ❑ pneumonia

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ cancer
- ❑ heart problems
- ❑ high blood pressure
- ❑ diabetes
- ❑ stroke
- ❑ depression
- ❑ tuberculosis
- ❑ thyroid problems
- ❑ blood clots

During the past month have you been feeling down, depressed or hopeless? **YES NO**
During the past month have you been bothered by having little interest or pleasure in doing things? **YES NO**
Is this something with which you would like help? **YES YES, BUT NOT TODAY NO**

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? **YES NO**

Please list any medications you are currently taking including dosage and amount per day. This includes but is not limited to pills, injections, skin patches, etc.

1. _____ 2._____ 3._____

4. _____ 5. _____ 6._____

Have you ever taken steroid medications for any medical conditions? **YES NO**
Have you ever taken blood thinning or anticoagulant medications for any medical conditions? **YES NO**

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. _____ 2._____ 3._____

What date (roughly) did your present symptoms start?_____

What do you think caused your symptoms? _____

My symptoms are currently: ❑ **Getting Better** ❑ **Getting Worse** ❑ **Staying about the same**

Treatment received so far for this problem (chiropractic, injections, etc) _____

Please list special tests performed for this problem (x-ray, MRI, labs, etc) _____

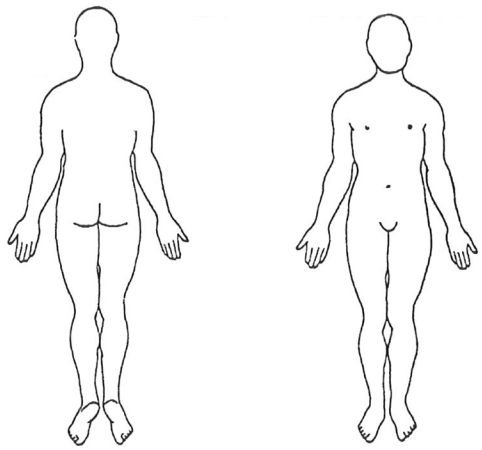
Have you ever had this problem before: ❑ **Yes** ❑ **No** **When**_____ **Treatment rec'd**_____

How long did it take for you to feel better? _____

Body Chart:

Please mark the areas where you
feel symptoms on the chart to the right with
the following symbols to describe your symptoms:

↓ **Shooting/sharp pain**
O **Dull/aching pain**
||| **Numbness**
= **Tingling**



My symptoms currently: ❑ Come and go ❑ Are Constant ❑ Are constant, but change with activity

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Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:
1. _____
2. _____
3. _____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:
1. _____
2. _____
3. _____

How are you currently able to sleep at night due to your symptoms?
❑ No problem sleeping ❑ Difficulty falling asleep ❑ Awakened by pain ❑ Sleep only with medication

When are your symptoms worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise
When are your symptoms the best? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

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Using the 0 to 10 the scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:

Your current level of pain while completing this survey:_____
The best your pain has been during the past 24 hours: _____
The worst your pain has been during the past 24 hours: _____

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient Name: _____ **Signature:**_____ **Date:**_____

Revised 1/30/14