NORTH SHORE MYOFASCIAL PHYSICAL THERAPY P.C.

1660 Rte. 112, Suite E
Port Jefferson Station, NY 11776
Office: (631) 996-2954 Fax: (631) 996-2958

Date: ___/___/___ Referred By: _____

Last Name: _____ First Name: _____ M.I. ____

Address: _____

City: _____ State: _____ Zip: _____

Sex: ❒Male ❒Female Marital Status: ❒Single ❒Married ❒Divorced ❒Widowed

Email: _____

Phone (H): ____-____-____ (C): ____-____-____

Date of Birth: ___/___/___ SS#: _____

Referring Doctor's Name: _____,

Referring Doctor's Address: _____

Referring Doctor's Phone#: ____-____-____

Body Part(s) to Be Treated: _____ ***Surgery Date:** _____

How Did You Hear About Us? ❒**Doctor** ❒**Friend/Family** ❒**Insurance Company**

INSURANCE INFORMATION

Are you the insured? ❒Yes ❒No

Primary Insurance: _____

Insurance ID #: _____

Local Union # (If Magnacare): _____

Insurance Company Phone #: ____-____-____

Plan Type (HMO, PPO, etc.): _____ Group Number: _____

Effective Date: ___/___/___

Pre-Cert/Referral Required? ❒Yes ❒No Deductible: $_____ **Co-Payment:** $_____

If you are not the policy holder please provide the following information:

Policyholders Name: _____

Relationship to patient: ❒Spouse ❒Child ❒Parent

DOB: ___/___/___ SS#: ____-____-____

Secondary Insurance: _____

ID #: _____

*Are you currently seeing a **Chiropractor** for this condition? ❒Yes ❒No

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(Please complete this section if not using your own private insurance).

No Fault Information (required by NYS)

Date of Injury: ___/___/___ Claim #: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

Adjusters Name: _____ **Phone #:** ___-___-___ **Ext:** ____

Fax #: ___-___-___ **State (If No Fault Accident):** _____

Worker's Compensation Information (required by NYS)

Date of Injury: ___/___/___ Date Last Worked: ___/___/___

WCB#: _____

Your Social Security Number: _____

Insurance Co. Name: _____

Carrier Case #: _____

Insurance Carrier Address: _____

Case Worker's Name: _____ **Phone #:** ___-___-___ **Ext:** ____

Fax #: ___-___-___

PATIENT SIGNATURE: _____ **DATE:** ___/___/___
(all patients)

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Patient Bill of Rights
(Please keep this for your records)

North Shore Myofascial Physical Therapy will protect the privacy of your health information, medical records, and any such medical and personal information from those other than directly related to your medical care. North Shore Myofascial Physical Therapy will use your information to coordinate your treatment; to keep your treating physician(s) up to date on your status in therapy; to obtain payment for treatment; to conduct internal audits and evaluating quality of care reviews. We also provide information when required by law. Please review the intake paperwork you were asked to complete during your registration with us. If you have any questions or special needs, please do not hesitate to talk with your therapist or to our billing specialist.

You have the right to:

-receive courteous professional service
-ask for clarification on your treatment plan and diagnosis
-review or obtain a copy of your personal health information
-request that we complete or correct any inaccurate information in your record
-request a list of individuals we release medical information to
-request in writing specific persons or agencies not to receive specific information
-speak to the billing specialist or owner of our company

We ask that you:

-respect others in our clinic both verbally and non-verbally
-try to keep to your appointment, and to call as soon as possible if there are any changes to be made
-keep us aware of any changes in your condition or doctor appointments
-respect the privacy of others and maintain confidential items of interest you may learn

While we want you to enjoy physical therapy during your time with us, I want to assure you that you are always welcome to call us to voice a concern, ask a question, or to pass along a compliment. If you feel there is a need to speak to us please contact:

Marie Francis, President
Ilene Horan, Office/Billing Manager
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MEDICAL HISTORY QUESTIONNAIRE

Your medical history is an essential component of your initial evaluation and we ask that you complete all applicable sections. If you need assistance, please feel free to ask our registrar. If you are unsure of any information, please leave it blank. Your therapist will review your responses with you during your initial evaluation.

Name: _____ **Date:** ___/___/___

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed **Age:** _____

DOB: ___/___/____

Presently at work? ☐ Yes ☐No **If not, last date worked:** ___/___/____

Occupation: _____

Present leisure activities:

_____

_____

Activities prevented because of pain:

_____

Current Weight: _____lbs. ☐ **Gain or** ☐ **Loss over past year:** _____lbs.

CURRENT HISTORY

Check type of Injury:

1. ☐ Motor Vehicle Accident
2. ☐ Fall
3. ☐ Lifting Injury
4. ☐ Other

Date?	Hospitalized?
_____	☐ Yes ☐No
_____	☐ Yes ☐No
_____	☐ Yes ☐No
_____	☐ Yes ☐No

Do you engage in any of the following?

		Describe type and frequency:
1. Exercise	☐ Yes ☐No	_____
2. Smoking	☐ Yes ☐No	_____
3. Alcohol	☐ Yes ☐No	_____
4. Coffee/Caffeine	☐ Yes ☐No	_____

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Operations/Hospitalizations (description and date):

_____

_____

List all medications you take) identify all prescription medications and over-the-counter medications including vitamins, laxatives, hormones, pain meds, sedatives, antacids:

_____

_____

Do you have any allergies? Please list:

_____

Do you have any implanted devices? (i.e. pacemaker, stents, mesh, metal etc.):

_____

Very Important: What are the top 3 goals you wish to reach while receiving treatment here? (what are the *specific* activities you wish to be able to do that you cannot do because of pain or weakness?)i.e. sleeping, stairs, driving, walking, etc.

1._____

2._____

3._____

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REVIEW OF SYSTEMS

Please check **any** conditions considered chronic in nature or are being **actively treated** by your health care provider:

HEAD/NECK

Headaches	☐	Neck Swelling / Lumps	☐
Change in Vision or Hearing	☐	Trouble Swallowing	☐

CARDIOVASCULAR

High Blood Pressure	☐	Irregular Heartbeat	☐
Blood Clots	☐	Palpitations	☐
Chest Pain (Angina)	☐	Leg/Ankle Swelling	☐
Varicose Veins	☐	Cramps in legs when walking	☐
Heavy Chest Pressure	☐	Cramps in legs at night	☐
Coronary or other Heart Disease	☐	Calf tenderness	☐

RESPIRATORY

Asthma	☐	Chronic Cough	☐
Lung Disease	☐	Coughing up blood/sputum	☐
Unusual Shortness of Breath	☐	Wheezing	☐

DIGESTIVE

Chronic Indigestion/Heartburn	☐	Blood in Stools	☐
Ulcer Disease	☐	Liver Disease	☐
Repetitive Nausea, Vomiting	☐	Diarrhea	☐
Intestinal Disease	☐	Gall Bladder Disease	☐
Abdominal Pain	☐	Constipation	☐
Black Stools	☐		

NEURO/PSYCHE

Dizziness	☐	Seizures	☐
Fainting	☐		

MUSCULOSKELETAL

Gout	☐	Back Pain	☐
Joint Pain/Swelling	☐	Weakness: Arms/Legs	☐
Arthritis	☐	Numbness/Tingling	☐

OTHER

Diabetes	☐	Diet Controlled	☐
High Cholesterol/Triglycerides	☐	Rheumatoid Arthritis	☐
Thyroid Disorder	☐	Insulin Dependent	☐
Unusual Hair Growth/Loss	☐	Insomnia	☐
Heat/Cold Intolerance	☐		

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I hereby acknowledge that I have filled out this MEDICAL HISTORY QUESTIONAIRE honestly and to the best of my knowledge. I have not withheld any information, medical or otherwise, from North Shore Myofascial Physical Therapy P.C that could negatively affect my health or the success of my treatment.
I also promise to update North Shore Myofascial Physical Therapy P.C. should my physician inform me of any changes thereof that could negatively impact or interfere with my health or physical progress while being treated.

Patient Name: _____ Signature: _____

Date: ___/___/____

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This **AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION** permits North Shore Myofascial Physical Therapy P.C. to use or disclose your protected health information (PHI). This authorization is voluntary. You may refuse to sign this authorization, but then North Shore Myofascial Physical Therapy P.C. will not be able to release your information. You may revoke this authorization at any time by writing to the address shown at the top of this page. A copy of this signed authorization will be available to you, but you should retain a copy for your records.

SECTION 1: PLEASE TELL US WHO YOU ARE

Name: _____ DOB: _____

Address: _____

Phone: Home: _____ Cell: _____

SECTION 2: WHAT IS THE PURPOSE OF THIS AUTHORIZATION?

- To authorize the identified persons and/or organizations to discuss orally with North Shore Myofascial Physical Therapy P.C. the PHI as permitted by Health Insurance Portability and Accountability Act (HIPPA) Privacy Rule.
- To authorize the identified persons and/or organizations to inspect and/or obtain copies of the PHI as permitted by the HIPPA Privacy Rule.

SECTION 3: WHO IS AUTHORIZED TO RECEIVE YOUR PROTECTED HEALTH INFORMATION (PHI) FROM NORTH SHORE MYOFASCIAL PHYSCIAL THERAPY P.C.?
Designated Representative:_____

SECTION 4: WHEN DO YOU WANT THIS AUTHORIZATON TO EXPIRE?
Two years from the date I signed this authorization.

SECTION 5: SIGNATURE

I understand that if the entity authorized to receive my PHI is not a health plan, health care provider, or other covered entity as described by the HIPPA Privacy Rule, the released information may no longer be protected by federal privacy laws, rules and regulations. I understand that I am not required to sign thus form, but if I do not sign this form, it will not be considered valid and will be returned. I understand that I may revoke this authorization at any time by notifying North Shore Myofascial Physical Therapy P.C. in writing. I agree that this information is true and correct. I sign this authorization under penalties of perjury and attest that North Shore Myofascial Physical Therapy P.C. has permission to treat me.

Patient Signature: _____ Date: _____

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Patient Name: _____

Welcome to North Shore Myofascial Physical Therapy P.C. This is our **APPOINTMENT POLICY CONSENT FORM**. We take great pride in the quality of care that we deliver. In effort to maintain this high-level of care, we have instituted guidelines regarding cancellations/no shows/lateness. Compliance with this policy will allow patients to receive their treatment in a timely and efficient manner, promoting optimal care while receiving treatment at North Shore Myofascial Physical Therapy P.C.

1. Once appointments are scheduled, patients are expected to attend each and every session at the designated time.

2. If you are going to be more than 10 minutes late for a scheduled appointment, please call to determine whether your physical therapist will still be able to see you that day.

3. All cancellations must be communicated to the front desk.

4. If you fail to show up to your appointment without notifying us or cancel in less than 24 hours, you will be charged $25 for a no-show visit.

5. If you cancel or fail to show three consecutive visits, your physician will be notified and you may be **discharged** from care. Please let us know when problems arise so we can help you.

6. North Shore Myofascial Physical Therapy P.C. reserves the right not to reschedule patients who have been discharged for failing to show for prior scheduled appointments.

We appreciate your understanding and cooperation with this policy.

I have read, understand, and agree to abide by the aforementioned policy.

Authorized Signature: _____ Date: _____

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Patient Benefits Agreement

PLEASE READ CAREFULLY!

Patient responsibility for out of pocket insurance costs:

Please be advised that if your insurance benefits indicate that you have a deductible, coinsurance (percentage), or co-pay for Physical Therapy services we are obligated by the insurer to collect these fees. In addition, it is our office policy to collect these fees at the time of **each** office visit. Exceptions may apply if your matter has been communicated to the front desk or owner.

Allow us to clear up some common terminology:

Deductible: A lump sum that the insurer states that the patient is responsible for covering BEFORE the insurance company begins paying for services.

Co-insurance: A percentage amount that the patient is responsible for of the total amount allowed, per visit. (Ex: Insurer allows $100 for office visit; @ 20% co-insurance, patient pays $20, insurer pays $80.)

Co-pay: Specified amount set forth by insurance company for which the patient is responsible per visit. It is **ILLEGAL** to waive a co-pay.

******We accept cash, check, and Visa, Mastercard, American Express, and Discover.******

Please Initial:

_____ I understand that I will pay all treatment fees directly to North Shore Myofascial PT.

_____ I understand that I am responsible for my deductible, co-pays, and all late cancellation or no-show fee. (The NSMPT no-show/cancellation fee is $25)

_____ I hereby state that I am not eligible for NY No-Fault or NY Workers Compensation

I agree to all of the terms stated above.

Name: _____ Date: _____

Signature: _____

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Patient Exercise Agreement

I _____ hereby agree that during the course of my treatment at North Shore Myofascial Physical Therapy, I will not perform any exercises or use any equipment that are not specifically part of my supervised therapeutic exercise program. I understand that this may cause unexpected injury or worsening of my current injury and/or pain level. I will only perform the particular exercises and use the particular exercise equipment specifically designated by my treating physical therapist.

Signature: _____ Date: _____

***If you are unsure about the above statement please consult the front desk or speak to your physical therapist.

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INFORMED CONSENT FOR TREATMENT

Patient Name: _____

1. I authorize the performance of physical therapy evaluation and successive treatments.

2. I understand that the services will be provided by physical therapists and physical therapy assistants employed by North Shore Myofascial Physical Therapy P.C.

3. I have received a copy of the ***Appointment Policy Consent*** form for North Shore Myofascial Physical Therapy P.C. I understand and agree to comply with those policies.

4. I have received a copy of the ***Authorization to Disclose Protected Health Information*** form for North Shore Myofascial Physical Therapy P.C. I authorize the use and disclosure of my health information to treat me and arrange for my care, to seek and receive payment for services given to me, to send appointment reminders via mail or phone, and for the business operations of North Shore Myofascial Physical Therapy P.C.

5. I received a copy of the ***Patient Bill of Rights.***

6. Any questions I have had to the above have been fully answered.

7. I fully understand the conditions of this consent and have no additional questions.

Authorized Signature: _____ Date: _____

Relationship to Patient: _____

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Consent for Outpatient Physical Therapy Treatment

Authorization

I hereby authorize licensed Physical Therapists and/or Physical Therapist Assistants to provide medical care and administer such treatment as deemed necessary or advisable and prescribed to the named patient or myself each time presenting to the facility at 1660 Rte. 112, Suite E. To the extent possible I have been informed of the risks and complications as well as the potential benefits that may occur and alternatives that may be available.

I acknowledge that no guarantees or assurances have been made to me concerning the results intended from my treatment.

Medicare Patients

I authorize any holder of medical information about me to release the Social Security Administration or its intermediaries or carriers any information needed for this or any related claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

Guarantee of Account

For and in consideration of services rendered to (name)_____ by North Shore Myofascial Physical Therapy P.C., I hereby agree to pay the full bill for all charges that are not covered or that are not paid to North Shore Myofascial Physical Therapy P.C. by insurance or Worker's Compensation, or any balance due that is not covered by insurance or excluded by co-insurance clause. I understand that any payments directed to me by my insurance company, for the intent of payment to North Shore Myofascial Physical Therapy P.C., must be forwarded directly to North Shore Myofascial Physical Therapy P.C. by me.

I understand that I have a $_____ co-payment for each office visit. These payments may be made on a daily or weekly basis. ***Please Initial*** _____

Release of Information

I permit North Shore Myofascial Physical Therapy P.C. to disclose all or part of the above patient's medical records to any person, corporation, or agency when required for collection of benefits or payment of charges.

Assignment of Benefits

I assign to North Shore Myofascial Physical Therapy P.C. all benefits from any corporation, agency and/or person for the services rendered. I authorize payment of these benefits directly to North Shore Myofascial Physical Therapy P.C.

I confirm that I have read and fully understand the above statements.

Patient Signature:_____ **Date:**_____

Relative or Guardian (If patient is under age 18)**:**_____

Relationship: _____

Signature:_____