New Patient Information

Armonk Physical Therapy
& Sports Training, PLLC

Name_____ Date: ____/____/____

Address_____ City_____ State_____ Zip_____

Home Phone (_____)_____ DOB ____/____/____ S.S. #_____

Cell Phone (_____)_____ E-Mail Address_____

Marital Status ____ Emergency Contact_____ Phone_____ Relationship: _____

Employment Information

Employer_____ Address_____

Occupation_____ Work Phone (_____)_____

How did you find our facility? _____

Referral Information

Referring Physician_____ Phone _____

Diagnosis_____ Date of Onset_____

Describe the problem(s) for which you seek physical therapy? _____

What happened? _____

What are your goals for Physical therapy? _____

Are you seeing anyone else for your condition(s)? (Check all that apply.)

☐ Acupuncturist	☐ Chiropractor	☐ Massage Therapist	☐ Osteopath
☐ Orthopedist	☐ Rheumatologist	☐ Neurologist	☐ Cardiologist
☐ OB/GYN	☐ Other_____		

General Health Status:

Please rate your health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor Height _____ Weight_____

Have you had any major life changes in the past year? (I.e. baby, job change, death in the family) ☐ Yes ☐ No

Do you currently smoke? ☐ Yes ☐ No Have you smoked in the past? ☐ Yes, year quit? _____ ☐ No

How many days/week do you drink alcoholic beverages (on average)? _____

Do you exercise beyond normal daily activities and chores? ☐ Yes ☐ No

How many days/week? _____ Describe exercise._____

_____

357 Main Street, Armonk, NY 10504

914.273.0800

Family History

Indicate whether your mother, father, sibling suffered from any of the following condition(s) and age of onset if known.

☐ Heart disease_____ ☐ Hypertension_____ ☐ Stroke_____ ☐ Cancer_____

☐ Diabetes_____ ☐ Psychological_____ ☐ Arthritis_____ ☐ Osteoporosis_____

☐ Other_____

Medical/Surgical History: *(Check if you have ever had any of the following.)*

☐ Arthritis	☐ Broken bones/fractures	☐ Multiple Sclerosis	☐ Epilepsy/Seizures
☐ Vascular Disease	☐ Heart Problems	☐ Skin Disease	☐ Prostate Disease
☐ Stroke	☐ Allergies	☐ Pregnancy	☐ Growth Problems
☐ Lung Problems	☐ Head Injury	☐ Recent Pregnancy	☐ Infectious Disease (Hepatitis)
☐ OB/GYN Problems	☐ Muscular Dystrophy	☐ Low Blood Sugar	☐ Blood Disorders
☐ Parkinson	☐ Thyroid Problems	☐ Ulcers/Stomach	☐ Pelvic Inflammatory Disease
☐ Osteoporosis	☐ Cancer	☐ Kidney problems	☐ Depression
☐ Diabetes/High Blood Pressure		☐ Complicated Pregnancy	

☐ Recent Injury_____

☐ Other_____

Within the past year, have you had any of the following symptoms*? (Check all that apply.)*

☐ Chest pain	☐ Shortness of breath	☐ Joint pain/swelling	☐ Loss of appetite
☐ Bowel Problems	☐ Urinary Problems	☐ Hearing problems	☐ Heart Palpitations
☐ Loss of balance	☐ Pain at night	☐ Nausea/vomiting	☐ Weight Loss
☐ Fever/chills/sweats	☐ Vision problems	☐ Cough	☐ Coordination problems
☐ Difficulty walking	☐ Difficulty sleeping	☐ Weight gain	☐ Headaches
☐ Weakness in arms/legs	☐ Dizziness/blackouts	☐ Difficulty swallowing	

☐ Other_____

Medications:

Do you take any prescription medication? ☐ Yes ☐ No

If yes, please list: _____

_____

Do you take any nonprescription medication? ☐ Yes ☐ No

Check all that apply.

☐ Advil/Aleve ☐ Aspirin ☐ Tylenol ☐ Antihistamines ☐ Decongestants

☐ Herbal Supplements ☐ Antacids ☐ Other_____

Within the past year, have you had any of the following tests? *(Check all that apply.)*

☐ Angiogram	☐ Arthroscopy	☐ Biopsy	☐ Bone-scan	☐ Blood test	☐ CT scan
☐ EKG	☐ Myelogram	☐ Nerve conduction	☐ Stress test	☐ X-Rays	☐ MRI

☐ Other_____

• Comments_____

_____

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Armonk Physical Therapy & Sports Training, PLLC

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MHSc, OCS

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Visit or web site:
www.ArmonkPTST.com

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SUMMARY OF NOTICE OF PRIVACY PRACTICES

All communication regarding our privacy practices including form requests and complaints, should be directed to:

PHI Privacy Administrator
357 Main Street
Armonk, NY 10504
Phone (914) 273-0800
Fax (914) 273-9287

Trust and confidentiality between you and your physician are not new. With electronic transmission of information, and casual travel and relocation of people's jobs and lives, however, are new. It is because of the latter that these agreements between doctors and patients have been formalized into law. This summary will assist you in understanding the attached ***Notice of Privacy Practices*** which contains detailed descriptions of how our office protects your health information, protects your rights as a patient, and outlines our common practices in dealing with patient health information. Please refer to that *Notice* for further information.

Health Information Uses and Disclosures.

In our medical practice, we routinely record, use and disclose your health information in order to treat you and to assist other health care providers in treating you. We also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services that we or other health care providers give to you. Finally, we may need to use and disclose your health information for certain limited business operational activities such as practice management, training, licensing, accreditation and quality assessment.

Other Uses and Disclosures Not Under Your Control.

We may need to disclose your health information without your written authorization in the following situations:

- To contact you by telephone, fax and regular or electronic mail to remind you of your appointments or to respond to your questions.
- To family members or close friends who are involved in your health care;
- For purposes of public health and safety, such as to the FDA to report product defects or incidents;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- For research purposes of a limited nature in a limited manner;
- For providing benefits under Workers Compensation;
- To the Military and Department of Veterans Affairs;
- To law enforcement authorities to assist in apprehending criminal offenders;
- To governmental authorities for prevention of child abuse or domestic violence;
- When required by law, search warrants, subpoenas or court orders;
- To Federal, State and Local law enforcement authorities involved in security activities as required;

Uses and Disclosures Controlled by You.

We will not use or disclose your health information without your prior written authorization, except for those uses we have stated in greater detail in the *Notice of Privacy Practices*.

Your Patient Rights.

As our patient, you have the following rights:

- To receive a Notice of Privacy Practices, which this summarizes.
- To get access to and/or a copy of your health information;
- To request that we communicate with you confidentially, by reasonable alternative means;
- To request restrictions on how we handle or disclose your health information;
- To request amendments to your health information;
- To request and receive an accounting of certain disclosures which we made of your health information.

Should you have any questions, concerns or complaints regarding our privacy practices, now or in the future, you will find the details of whom to contact on the current *Notice of Privacy Practices*.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES #_____
Version Serial# State

I acknowledge that I was provided a copy of the Notice of Privacy Practices from the above named Medical Care Organization/Provider for me to keep and that I have read (or had the opportunity to read if I so chose) and understood the Notice. This acknowledgement is requested per government statute.

X _____ _____
PATIENT Name (please print) Print Name of Parent/Responsible Party (if applicable)

X _____ ___/___/___ _____
SIGNATURE of Patient/Parent/Responsible Party DATE Relationship to Patient

Patient's Date of Birth ___/___/___ Patient Identification # (or Social Security No.) _____

ARMONK PHYSICAL THERAPY & SPORTS TRAINING, PLLC

357 Main Street
Armonk, NY

Welcome to ARMONK PHYSICAL THERAPY & SPORTS TRAINING. In order to insure that you receive the highest quality of care possible, we kindly ask that you familiarize yourself with the following:

- **CANCELLATION POLICY – There will be a $75.00 charge for missed and/or cancelled appointments inside of the 24 hour period. When you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. If you do not call or cancel a second appointment within the 24 hour time period, you will be charged the full office fee of $195.00. This fee <u>will not</u> be covered under your insurance carrier.**

- **PAYMENT POLICY** – We will submit your claims and await reimbursement from your insurance carrier as a courtesy. **Your coinsurance/deductible is due at each visit.** We will verify and inform you of your physical therapy benefit. We are not responsible for incorrect information provided by your insurance carrier. **However, it is your responsibility to know your policy and what your coverage affords you.** If at any time your insurance carrier denies payment or if you have exceeded your benefit limit for physical therapy, you will be responsible to pay for those services in full. We are out of network with **<u>ALL</u>** the secondary insurance carriers to Medicare, you may be responsible for what Medicare does not cover, including the 20% balance and yearly deductible.

- Your insurance carrier may request your medical records in order to process your claims. By signing below, you authorize **ARMONK PHYSICAL THERAPY & SPORTS TRAINING** to release your medical records to your insurance carrier in order to process any pending medical claims.

- **If you are being seen for physical therapy without a referral, there is a possibility that the insurance may not cover treatment services and you may be responsible for 100% of the charges.**

- **In the event your account balance is over 60 days past due, the account will be placed in collections and an additional 25% of your total balance due will be applied.**

- Please notify us of any changes in residence, insurance coverage, medications, or in your medical condition.

Thank you for your cooperation and choosing ARMONK PHYSICAL THERAPY & SPORTS TRAINING for your pelvic floor therapy services. Please sign below upon your full understanding of the terms above.

_____ _____/_____/_____

Signature of Patient/Guardian **Date**

_____ _____/_____/_____

Signature of Therapist **Date**

ARMONK PHYSICAL THERAPY & SPORTS TRAINING

CREDIT CARD ON FILE AGREEMENT (Optional)

*

At Armonk Physical Therapy & Sports Training, we try to accommodate our clientele the best way we can. We want to make things easier for you. Since we required payment at the time of each visit, we are looking to eliminate any tedious processes that may inconvenience you. If you would like to opt into automatic charges, please complete the form below. Otherwise, please remember to stop at the desk at each visit to make payment.

I _____, **authorize** Armonk Physical Therapy, PLLC to keep my credit card on file and to charge at each visit.

ACCOUNT TYPE: ☐ **VISA** ☐ **MASTERCARD** ☐ **AMEX** ☐ **DISCOVER**

CARDHOLDER NAME: _____

CARD NUMBER: _____

EXPIRATION DATE: _____

V-CODE: _____

PATIENT NAME: _____

I understand this form is valid for the length of my current treatment. In the event I am discharged from therapy or choose to discontinue my course of treatment, I authorize any unpaid balance to be charged to the above credit card.

CARDHOLDER SIGNATURE: _____ **DATE:** _____

☐ **I decline keeping a credit card on file at this time.**

Signature: _____ **DATE:** _____

*****IF YOU CHOOSE TO <u>NOT</u> KEEP A CREDIT CARD ON FILE, PLEASE STOP AT THE DESK EACH VISIT FOR PAYMENT, THANK YOU.*****