Grand Island
PHYSICAL THERAPY PC

Name:_____Date of Birth:_____Age:_____

Address:_____City:_____Zip:_____

Soc. Sec. #:_____Phone:_____ C:_____

Emergency Contact:_____Phone:_____

Email address:_____Are you a MOG member? Yes N o

Family Physician:_____Referring Physician: _____

Date of Injury: _____Date of Surgery:_____

Employer:_____Phone:_____

Employer's Address: _____

Physical Therapy is the profession whose expertise is evaluating and treating movement disorders whether they are related to a surgical procedure a disease, or a dysfunction. As *Physical Therapists* we will not only concern ourselves with your specific diagnosis, but we also will assist and encourage you to consider and analyze your overall health and fitness. We take a holistic approach to your treatment and account for your physical, emotional, and spiritual well being. ***WELCOME to our Practice!***

Assignment and Release Agreement
I understand my insurance coverage and that I am personally responsible for payment to Grand Island Physical Therapy for services (including co-payments and deductibles) not covered by my insurance company. I also understand that if I become delinquent on my account, I will be responsible for collection fees of 35% and/or court fees associated with the collection of this debt.

I understand that my insurance will only pay for pre-authorized physical therapy treatments. I also understand that it is my responsibility to keep track of the number of visits for which I am approved, and agree to pay Grand Island Physical Therapy $45.00 per visit if I have received more treatments than my insurance company has allowed.

I hereby authorize payment of medical benefits to Grand Island Physical Therapy for services rendered. I also authorize the release of any information necessary to process my claims.

While we do understand that emergencies arise, if you are unable to keep an appointment, we require 24 hours notice of cancellation. "No Show" appointments and appointments cancelled with less than 24 hours notice will be assessed a charged. This charge is solely the patient's responsibility and it not billable or reimbursable by insurance or 3rd party payors.

Signature:_____Date: _____

If minor, parent or guardian signature: _____

May we ask how you heard about our office? _____

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Notice of Identity Security and Privacy Practices

This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health insurance portability and Accountability act of 1996 (HIPPA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to provide you with the following important information.

1. How we may use and disclose your health information.
2. Your privacy rights.
3. Our obligations concerning the use and disclosure of your health information.

The following categories describe the different ways in which we may use and disclose your health information.

1. Treatment – Therapists and staff may use or disclose your health information in order to treat you or assist others in your treatment. Additionally, we may disclose your health information to other who may assist in your care, such as your spouse, child, or parents.
2. Payment – Our practice may use your health information to bill and collect payments for the services you receive from us. We may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose this information to obtain payment from third parties that may be responsible for such costs, such as family members.
3. Health care operations – We may need to use and disclose your health information to be able to run our practice at the highest clinical standards and as effectively as possible. This could be used to evaluate the performances of our therapists and staff, to determine if our treatment plans are effective, or determine if there are other services we should be offering. We many also compare our clinical data with other practices, review it with medical students medical faculty, technicians, and other from teaching and learning purposes. We will strive to remove information that identifies you from this medical information.
4. Disclosures required by law. Our practice will use and disclose your health information when we are required to do so by federal, state, or local law.
5. Appointment reminders and sign in sheets – We may want to call you by phone for appointment reminder purposes. Please advise us if you do not want us to call and leave appointment reminder messages at your home, possibly on your answering machine, or with any co-worker at your place of employment. We may also use a “sign-in” sheet at the front desk, for purposes of logging our patients as they arrive. We will ask for you to sign your first name only to insure your privacy rights.

Your rights regarding your health information

1. Communications – You can request that our practice communicates with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. We will accommodate reasonable requests.

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2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information only to certain individuals involved in your care or the payment of your care, such as family members and friends. We are not required to agree to your request; however if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records. You must submit your request in writing to Grand Island Physical Therapy (GIPT), Attn: Office Manager, 1801 Grand Island Blvd., Grand Island, NY 14072.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by our practice. To request an amendment, your request must be made in writing and submitted to GIPT, Attn: Office Manager, 1801 Grand Island Blvd., Grand Island, NY 14072. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of the Notice or Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact the Office Manager at (716)773-4323.
6. Right to file a complaint. If you believe your privacy rights have been violated you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. The file a complaint with our practice, contact the Office Manager at (716)773-4323. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have read and understand this practice's Notice of Privacy Practices. I also understand that if I have any question or complaints regarding my privacy right that I may contact the Office Manager. I further understand that the practice will offer me updates to this Notice of Privacy Practices should it be amended, modified, or changed in any way.

_____

Patient or Representative Name (please print)

_____ _____

Patient or Representative Signature Date

Grand Island Office
1801 Grand Island Blvd. Grand Island, NY 14072
(P) 716.773.4323 · (F) 716.773.9418

Kenmore Office
1491 Sheridan Dr., Ste 300 Kenmore, NY 14217
(P) 716.871.1100 · (F) 716.871.1102

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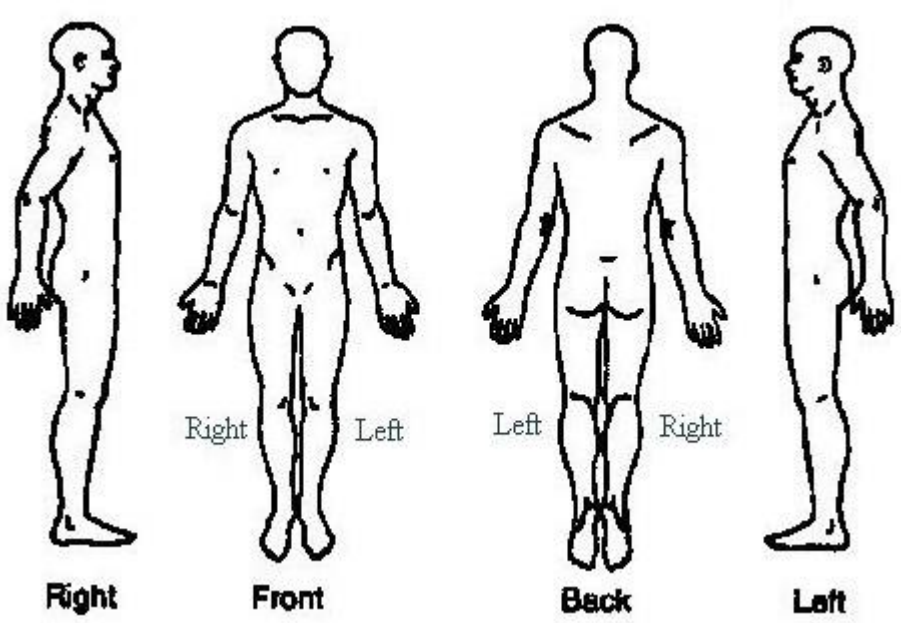
Name:_____Age:_____Date:_____

What is your primary problem?_____

Describe the nature of your pain:

☐ Constant (76-100%)	☐ Sharp Pain	/////
☐ Frequent (51-75%)	☐ Dull Pain	+++++
☐ Occasional (26-50%)	☐ Throbbing	ΔΔΔΔΔ
☐ Intermittent (25% or less)	☐ Numbness	=====
	☐ Burning	XXXXX
	☐ Pins & Needles	OOOOO
	☐ Shooting	•••••

Mark these drawings where you have pain or symptoms, according to the symbols above:



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)

Since this condition began your symptoms have (circle one): Decreased Remained the Same Increased

Your symptoms are worse in: Morning Afternoon Night Increased during the day Same all day

Any functional activities you are having difficulty with? _____

What do you hope to attain by attending therapy? _____

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

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If yes, whom did you see for that condition? MD Physical Therapist Occupational Therapist Chiropractor Other _____

When and what treatment did you receive? _____

Are you currently working? Yes No

If not, are you off secondary to this injury? _____

Occupation: _____

Do you exercise regularly? Yes No How often each week? _____

Your current stress level on a scale of 1 to 10 (1 being no stress)___

Medical History:

Past	Present	
☐	☐	High Blood Pressure
☐	☐	Angina
☐	☐	Heart Attack
☐	☐	Stroke
☐	☐	Asthma
☐	☐	HIV/Aids
☐	☐	Cancer Location: Date:
☐	☐	Tumor
☐	☐	Systemic Lupus
☐	☐	Hepatitis
☐	☐	Epilepsy
☐	☐	Diabetes
☐	☐	Rheumatoid Arthritis
☐	☐	Arthritis
☐	☐	Other
☐	☐	Tobacco Packs per day:
☐	☐	Drug or alcohol dependence

Do you have any allergies? _____

Do you have a pacemaker or other implantable electronic device? Yes No

For females, any chance you may be pregnant? Yes No

Any recent hospitalizations or surgical procedures? _____

Any recent unusual weight gain or loss? _____

Please list current medications and dosage, including over the counter medications: _____

_____

Patient Signature: _____ Date: _____

Therapist Signature – above information reviewed with patient.

_____ Date: _____