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NEW PATIENT PACKET

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Date:		☐ Male ☐ Female	
Patient's Name:		**Date of Birth**:	
Address:			
City, State:		**Zip Code:**	
Home #:	**Cell #:**	**Email:**	
Occupation:		**Height:**	**Weight:**
Emergency Contact:		**Phone #:**	
Best Means of Communication:	☐ Home # ☐ Cell # ☐ Email		

POLICY HOLDER INFORMATION

If you have Medicare as your insurance, please skip this section.

Policy Holder:	**Date of Birth:**

Referring Doctor:		**Phone #:**	
Check all that apply:	☐ Diabetes	☐ Pacemaker	☐ Epilepsy/Seizures
	☐ High Blood Pressure	☐ Infectious Diseases	☐ Migraine Headaches
	☐ Dizziness/Vertigo	☐ Cancer Type:_____	☐ Osteoporosis
	☐ Arthritis	☐ Lung Condition	☐ Heart Condition
	☐ Pregnancy	☐ Bruising/Bleeding Disorder	☐ Other

List any allergies (ie. medical, seasonal, etc.).	**List any surgeries.**

List your prescribed drugs and over-the-counter drugs (ie. vitamins, inhalers, etc.).

You may also provide a copy of your medications to the front desk. If you need more space, please feel free to use the back of the page.

Date:	Name:

MEDICAL SUMMARY FORM			
Describe your symptoms.			
How long have you been experiencing these symptoms?			
What are your goals for therapy?			
Have you seen a physical therapist for treatment of this condition?			☐ Yes ☐ No
Is your condition a result of a work-related injury?			☐ Yes ☐ No
Is your condition a result of a recent automobile accident?			☐ Yes ☐ No
Have you received any physical/speech therapy this year?			☐ Yes ☐ No
Are you currently enrolled in a homecare program?			☐ Yes ☐ No
You cannot be enrolled in a homecare program, while you are receiving outpatient physical therapy.			
Are you presently receiving any of the following therapies at this time?		☐ Additional Physical Therapy	☐ Acupuncture
		☐ Chiropractic	☐ Massage

HEALTH HABITS & PERSONAL SAFETY			
Exercise	☐ Sedentary (No exercise)		
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
Do you use tobacco? ☐ Yes ☐ No		**Do you drink alcohol?**	☐ Yes ☐ No
Have you had any recent changes in your weight or appetite?			☐ Yes ☐ No
Do you have a history of falls?			☐ Yes ☐ No
Do you feel unsteady or have a fear of falling?			☐ Yes ☐ No

Please read the following sections.

INSURANCE VERIFICATIONS

When we verify your eligibility and benefits for physical therapy, we do our best to record the most accurate and current information available to us by the insurance representative. However, this information may not always be correct. I understand that it is my responsibility to understand the scope and limitations of your insurance policy and I am financially responsible for all charges rendered, whether or not paid by your insurance company.

Please continue to read the following sections.
You may request a copy of this information at the front desk.

ASSIGNMENT OF BENEFITS

An assignment of benefits is an arrangement by which a patient requests that his or her health insurance benefit payments be made directly to a designated person or facility, such as a physician or hospital.

I, the undersigned patient, agency for the patient, or legal guardian, hereby grant permission to and authorize **Physical Therapy Group of Westchester, P.C.** to use of this signature on all insurance submissions. I also authorize this provider to represent me in any appeal process or claim denial appeal in order to collect payment from the appropriate insurance company and/or responsible party. I understand that I am financially responsible for any charges not covered by this assignment, which include, but are not limited to copays, deductibles and any other fees for services.

ACKNOWLEDGMENT OF PRIVACY PRACTICES

I hereby acknowledge that I have received, or have been given the opportunity to receive, and reviewed a copy of **Physical Therapy Group of Westchester, P.C.** Notice of Privacy Practice.

RELEASE OF INFORMATION

I authorize the release of any information, relating to any claim for benefits, to any insurance company, attorney or adjuster as necessary to process any claims for payment to **Physical Therapy Group of Westchester, P.C**. In addition, I permit a copy of this authorization to be used in place of the original. I understand that I may revoke this authorization at any time in writing.

CANCELLATION/NO-SHOW/LATE POLICY

I understand that **Physical Therapy Group of Westchester, P.C**. will charge a $50.00 fee for any of the following situations:

- Cancellation without a 24-hour prior notice
- Same day cancellation
- No-show

If you are running late to your appointment, we ask that you give us a call. We will try our best to accommodate, but there is no guarantee that you will get your full treatment.

CONSENT FOR TREATMENT

I, the undersigned patient or agency for the patient, authorize **Physical Therapy Group of Westchester, P.C.** to provide treatment for the duration of the appointment. When signing below as the legal guardian, I authorize this provider to examine and treat the minor without my presence (if applicable).

By signing below, I certify that I have read all of the information above and will abide by these policies.

X_____
Print

X_____ X_____
Signature **Date**