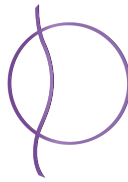

PERSPECTIVES
PHYSICAL THERAPY

PATIENT INFORMATION

Last Name: ________________________ First Name: ________________________ Date: _________________

Birthdate: ________________ Occupation: _________________________

Street Address: __________________________ City: __________________ State: _____ Zip: _____________

Work Phone: ______________________ Cell Phone: ______________________ Home: _________________

May we leave voicemail messages regarding your appointments at the following?

Home: Yes ________ No ________ Work: Yes ________ No ________ Cell: Yes ________ No ________

Sex: ________ Age: ________ Single ____ Married ____ Widowed ____ Separated ____ Divorced ____

Email address:

____

Chose clinic because/Referred to clinic by:

❑ Friend______________ ❑ Dr. ______________ ❑ Family ________________ ❑ Other________________

Referring Provider Information

Referring Provider: _________________________________

Office Address: __________________________ Office Fax: ______________________________

Office Phone: ___________________________ Office Email: ____________________________

EMERGENCY CONTACT

In case of emergency, please contact: _____________________________ Relationship: ________________

Phone Number: ___________________________ Secondary Phone Number: __________________________

The above information is true to the best of my knowledge:

____ _______________________

Patient/Guardian Signature Date

HEALTH HISTORY

Date of injury or onset of complaint(s):____

Briefly describe how you were injured or how complaints began (i.e. after tennis, bending....):

____

____

Where is your pain / injury located? __________________________

On a scale from 0 (no pain) to 10 (worst pain), please rate your current level:

0 1 2 3 4 5 6 7 8 9 10

Pain is becoming: ____ Better _______Worse ______ Same

Things that make the pain better: ____

Things that make the pain worse: ____

Have you had any treatment for this condition? Yes ___ No____

If yes, please describe: ____

List all over-the-counter and prescription medications you are currently taking for any reason: (include pills, injections, skin patch, etc.) ____

____

If you have any metal or other implants in your body, please describe where they are:

____ ____

Please check any of the following diagnostic studies completed for this condition:

□ X-Ray □ Electromyography (EMG) □ MRI □ Computed Tomography (CT Scan) □ Other______________

Have you ever been diagnosed with any of the following: (Circle YES or NO for each item)

YES NO Cancer If YES, please describe: _______________________________________

YES NO Heart Attack

YES NO Other Heart Condition, If YES, please describe_____________

YES NO Pacemaker

YES NO Epilepsy

YES NO Pregnant or think you might be

YES NO Kidney Disease

YES NO Anemia

YES NO Sleep Problems

YES NO High Blood Pressure

YES NO Respiratory Problems

YES NO Rheumatoid Arthritis

YES NO Asthma

YES NO Eye / Vision Problem

YES NO Diabetes

YES NO Headaches

YES NO Multiple Sclerosis

YES NO Osteoporosis

YES NO Stroke

YES NO Deep Vein Thrombosis

YES NO Thyroid

YES NO Emotional / Psychological Problems Problems

Please list any surgeries/other conditions for which you have been hospitalized. Date Surgery / Hospitalization/Reason____

____

What are your goals for physical therapy? ____

____

____

NOTICE OF ADVICE
Treatment under New York's Direct Access Law

Thank you for choosing Perspectives Physical Therapy PLLC as your physical therapy provider.

A physical therapist providing treatment in the practice of physical therapy without a referral from a physician, dentist, podiatrist, nurse practitioner, physician assistant, or midwife, in accordance with Education Law section 6731 (d) Article 136 may offer treatment for 10 treatments or 30 days, whichever comes first. Treatment may not be covered by a patient's health care plan or ensurer without a referral from a practitioner as listed above and that treatment may be a covered expense if rendered pursuant to such referral. Direct Access Law does not apply to patients who are covered under worker's compensation, no-fault insurance, Medicare, or to patients who have pending liability cases.

Treatment will begin on ______________________

____
Patient/Guardian Name

____
Patient/Guardian Address

________________________________ ____________________________
Patient/Guardian Signature Date

____
Physical Therapist Name

____
Physical Therapist Address

________________________________ ____________________________
Physical Therapist Signature Date

PATIENT INFORMATION CONSENT FORM

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board. It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.

You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.

You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

You have the right to inspect and copy your health information.

You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your protected health information made by us. You have a right to a paper copy of this Notice of Privacy Practices at any time upon request. We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us by calling this office at (516)243-7041. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to: DHHS, Office of Civil Rights 200 Independence Avenue, S.W. Room 509F HHH Building Washington, DC 20201 I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide the company above with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

Patient's Name (print) _________________________________

Patient's Signature ____________________________________ Date ___________________

INFORMED CONSENT & WAIVER OF LIABILITY

Waiver and Release of Liability In agreeing to receive care provided by Perspectives Physical Therapy PLLC, I agree as follows:

I fully understand and acknowledge that (a) the activities in which I will engage as part of the treatment provided by Perspectives Physical Therapy PLLC and equipment I may use as a part of that treatment have inherent risks, dangers, and hazards and such exists in my use of any equipment and my participation in these activities; (b) my participation in such activities and/or use of such equipment may result in injury or illness.

I have volunteered to participate in a program of health care (possibly including but not limited to physical therapy, weight training, etc) and to retain the services of Perspectives Physical Therapy PLLC, independent contractors and/or any future employees or independent contractors to receive said services. I will be given opportunity to ask questions and to have them answered to my satisfaction. I understand that I may decline treatment at any time.

By my participation in these activities and for use of equipment, I hereby assume all risks and dangers and all responsibility for any losses and/or damages whether caused in whole or in part by the negligence or the conduct of the representatives or employees of Perspectives Physical Therapy PLLC.

I, on behalf of myself, my personal representatives and my heirs, hereby voluntarily agree to release, waive, discharge, hold harmless, defend, and indemnify Perspectives Physical Therapy PLLC and their representatives, employees, and assigns from any and all claims, actions or losses for bodily injury, property damage, wrongful death, loss of services or otherwise which may arise out of my use of any equipment or participation in these activities. I specifically understand that I am releasing, discharging, and waiving any claims or actions that I may have presently or in the future for the negligent acts or other conduct by the representatives or employees of Perspectives Physical Therapy PLLC.

I have read and understood this INFORMED CONSENT and WAIVER & RELEASE OF LIABILITY and it accurately sets forth my intentions and I agree to be bound by its provisions.

Name (print) ___________________________________
Signature _______________________________________ Date _________________