



DANCE, ORTHOPEDIC & SPORTS PHYSICAL THERAPY

130 West 56th Street, Suite 6M, New York, NY 10019

T 212.246.3700 F 212.246.3701

DIAGNOSIS CODES

(For office use only)

- 1. _____
- 2. _____
- 3. _____
- 4. _____

New Patient Registration Information:

Patient Name: _____ Today's Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone (Day): _____ Phone (Eve): _____ Phone (Cell): _____

May We Leave Messages at the Numbers Listed Above When We Need to Contact You? Yes / No

Email Address: _____

Employer Name & Address: _____

Date of Birth: ____ / ____ / ____ Social Security Number: ____ / ____ / ____

Name of Person We Should Contact in Case of Emergency: _____

Phone Number and Relationship: _____

Referring physician: _____ Date of follow-up with referring physician: _____

How did you find out about PT Plus, P.C.? _____

Primary Insurance Coverage:

Name of Policy Holder: _____ Date of Birth of Policy Holder: ____ / ____ / ____

Insurance Company: _____ Name as it Appears on Card: _____

Policy #: _____ Group #: _____ Ins Co. Phone #: _____

Insurance Co. Address: _____

Is Policy Holder the Guarantor? Yes / No *If no*, name & address of person to be billed: _____

Release:

I hereby authorize PT Plus, P.C., to release medical information in accordance with federal privacy laws necessary to process this claim and request payment of benefits to the party who accepts assignment.

Signature of Patient or Guardian: _____ **Date:** _____

Consent for Treatment:

My signature below authorizes PT Plus, P.C., and its physical therapy staff to evaluate me and provide treatment for me in keeping with the diagnosis of the referring physician.

It is my understanding that my therapist will explain his or her findings to me as well as his or her plan of treatment.

I understand that I may ask questions of my therapist at any time and that I may elect not to participate in a recommended treatment or exercise at my sole discretion.

Signature of Patient or Guardian: _____ **Date:** _____



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PATIENT POLICIES

Referral / Prescriptions

New York State law requires that you must have a current prescription for physical therapy from a New York State licensed physician or nurse practitioner. If you are a Medicare patient, you are also required to return to your physician every thirty days to renew your prescription for physical therapy.

Lockers

We are a small facility and, as such, are unable to permit you to leave your belongings in a locker overnight. Kindly plan your visit so that you are able to transport your belongings on a daily basis.

Showers

Showers available for your use on every non-“M” floor of this building. The shower areas are unisex as designated by the signs outside each shower area. PT Plus will provide you with towels for your convenience.

Lateness

We schedule in such a way as to permit optimal time for your treatment. Accomplishing optimal intervention, however, requires that you arrive on time for your appointment. Your promptness will be greatly appreciated. If you arrive late, you will be billed for a full treatment session, but your treatment time will be adjusted accordingly. With the interest of giving you the best attention possible, we may refuse you treatment if we determine that the time remaining for your appointment is not sufficient to render beneficial care. In that event, you will incur a \$100.00 cancellation fee.

Cancellations

If you are unable to keep a scheduled appointment, we ask that you kindly give us 24 hours notice. Calling 24 hours in advance allows us to place another person waiting to be seen in your time slot. If you learn that you must cancel after our business hours, kindly leave a message on our voice mail system. Failure to cancel in advance will result in a \$100.00 charge to your credit card.

No Show

Patients who “no-show” will incur a \$100.00 charge on their credit card for each “no-show” and will also be discharged from our care after three offenses.

Payment

Deductibles, co-insurance payments, balances due and cancellation/no-show fees are expected before each daily session and may be made by credit card only. Our policy requires that you check in with our front desk personnel each and every treatment day to settle your account *before* entering the treatment area.

Signature

By signing below, I certify that I have read the above policies, understand them and will comply with them. I agree with PT Plus that it retains the right to charge my credit card for scheduled appointments missed by lateness, late cancellation or no-show activity, as described above.

Signature of Patient or Guardian: _____

Date: _____



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Payment Policy

Please read carefully the information in the checked area below and sign at the bottom of the page to indicate your full awareness of our payment policies and of your insurance benefits as they pertain to the physical therapy charges you will incur at our facility.

Your signature below indicates your agreement with PT Plus, P.C., that it is not responsible for any benefit discrepancies with your insurance carrier before, during or after the time of your care, and/or for any errors related to the verification of your benefits. You are encouraged to check directly with your carrier about verification of your benefits.

Direct Payment

My signature below indicates that I understand payment of my deductible and co-insurance fees (or payment in full, as appropriate to my individual insurance benefit profile) will be expected of me at the time of each treatment session. The payment plan I have agreed to with PT Plus, P.C., according to my individual insurance benefit profile, is described on the following page and attached to this form.

PT Plus, P.C., accepts Mastercard, Visa and American Express as methods of payment. For my records and convenience, PT Plus, P.C., will give a receipt to me at the time of each payment. Receipts for payment will contain all the necessary and pertinent insurance coding information required for reimbursement by my insurance carrier. I fully understand it is ultimately my responsibility to secure reimbursement from my insurance carrier for the physical therapy care that I receive. I understand PT Plus, P.C., will charge my credit card for any balance unpaid by my insurance carrier 90 days after submission of my claims.

By signing below, I understand that an imprint of my credit card is required on the date of my initial visit for the purpose of guaranteeing scheduled appointments against late cancellations and no-shows and for the purpose of balance billing any charges not covered by my insurance carrier.

Assignment to PT Plus, P.C. (Workers' Compensation patients only)

I hereby assign, transfer, and set over to the above named physical therapy facility sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my physical therapy care, to cover the costs of the care and treatment rendered to me or my dependant at said facility.

By signing below, I understand that an imprint of my credit card is required on the date of my initial visit for the purpose of guaranteeing scheduled appointments against late cancellations and no-shows and for the purpose of balance billing any charges not covered by my insurance carrier.

Signature of Patient or Guardian: _____ **Date:** _____



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Individual Insurance Benefit Profile:

Section One: Insured Patients Only

I have a health insurance policy which provides the following physical therapy benefits:

Number of PT visits allowed: _____ (circle one): *per condition / lifetime / calendar year*

Amount of annual deductible: \$ _____ Amount of deductible remaining to date: \$ _____

Deductible payment plan for PT Plus, P.C.: _____ per session x _____ sessions

Period of Deductible: *Jan 1 – Dec 31* (calendar year) / *Other* _____

PT co-insurance split (insurance / member): _____ / _____ %

Co-insurance amount due at the time of each visit: \$ _____

Approval/authorization required? (circle one) *Yes /No*.

Based on the information above, I understand that my co-insurance amount due at the beginning of each treatment session will be: \$ _____. PT Plus, P.C., retains the right to balance bill me for services denied or not covered by my insurance company on the 90th day after submission of claims.

Section Two: Uninsured Patients and Workers' Compensation Cases

I have no health insurance and will pay PT Plus, P.C., in full at the time of each visit.

I have an open Worker's Compensation case and have been assured by my case worker that _____ physical therapy visits at PT Plus, P.C., will be reimbursed by the insurance carrier. I agree to pay PT Plus, P.C., for all reimbursement monies sent to me by the insurance carrier for physical therapy services.

Section Three: Medicare Patients Only

I understand that PT Plus, P.C., retains the right to bill me for services denied or not covered by Medicare.

Signature of Patient or Guardian: _____

Date: _____



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CREDIT CARD INFORMATION SHEET

PATIENT NAME: _____

TYPE OF CREDIT CARD: VISA / MASTERCARD / AMEX

NAME (EXACTLY) ON CREDIT CARD: _____

CARD NUMBER: _____

SECURITY CODE: _____

EXPIRATION DATE: _____

ADDRESS WHERE CARD INVOICE IS SENT MONTHLY:

NAME: _____

STREET: _____

CITY: _____ STATE: _____ ZIP: _____

SIGNATURE: _____



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Outpatient Medical History

Name _____

1. Sex Male Female

2. Height _____ Weight _____

3. Are you Right-handed Left-handed

4. Cultural/Religious

Any customs or religious beliefs or wishes that might affect care? _____

5. Current Condition(s)/Chief Complaint(s)

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

When did the problem(s) begin (date)? ____/____/____
What happened? _____

Have you ever had the problem(s) before? Yes No
What did you do for the problem(s)? _____

Did the problem(s) get better? Yes No
About how long did the problem(s) last? _____

What makes the problem(s) better? _____

What makes the problem(s) worse? _____

What are your goals for physical therapy? _____

6. Occupation _____

7. Do you use a

- Cane Hearing aids
- Walker or rollator Dentures
- Manual wheelchair Pacemaker
- Motorized wheelchair Medicine Pump

Glasses, contact lenses Other _____

8. General Health Status

Please rate your health:

Excellent Good Fair Poor

Have you had any major life changes during past the year? (e.g., new baby, job change, death in family)

Yes No If yes, what? _____

9. Social/Health Habits

Smoking:

Currently smoke tobacco? Yes No

Cigarettes, # of packs per day _____

Cigars/Pipes, # per day _____

Alcohol:

On average, how many days per week do you drink beer, wine, or other alcoholic beverages? _____

If one beer, one glass of wine, or one cocktail equals one drink, how many drinks do you have on an average day?

Exercise:

Exercise beyond normal daily activities and chores?

Yes No

Describe the exercise: _____

On average, how many days per week do you exercise or are you physically active? _____

How many minutes on an average day? _____

10. Family History

Indicate family member (e.g., mother, father, brother, aunt, grandfather, etc.) and age of onset, if known.

Heart disease: _____

Hypertension: _____

Stroke: _____

Diabetes: _____

Cancer: _____

Psychological: _____

Arthritis: _____

Osteoporosis: _____

Other: _____

PLEASE COMPLETE REVERSE SIDE OF THIS FORM

PT PLUS

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11. Medical/Surgical History

Please check if you have ever had:

- | | |
|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Low blood sugar/hypoglycemia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Lung problems |
| <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Broken bones/ fractures | <input type="checkbox"/> Muscular dystrophy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Osteoporosis problems |
| <input type="checkbox"/> Circulation/vascular problems | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Repeated infections |
| <input type="checkbox"/> Developmental/growth problems | <input type="checkbox"/> Seizures/epilepsy |
| <input type="checkbox"/> Diabetes/high blood sugar | <input type="checkbox"/> Skin diseases |
| <input type="checkbox"/> Head injury | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Ulcers/stomach problems |
| <input type="checkbox"/> Infectious disease (such as tuberculosis, hepatitis) | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Other _____ | |

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

- | | |
|---|---|
| <input type="checkbox"/> Bowel problems | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Joint pain or swelling |
| <input type="checkbox"/> Coordination problems | <input type="checkbox"/> Loss of appetite |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Nausea/vomiting |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Pain at night |
| <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Dizziness or blackouts | <input type="checkbox"/> Urinary problems |
| <input type="checkbox"/> Fever/chills/sweats | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Weakness in arms/legs |
| <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Weight loss/gain |
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Other _____ |

Have you ever had surgery? Yes No

If yes, please describe and include dates:

Date: _____ Description: _____

Date: _____ Description: _____

Date: _____ Description: _____

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

- | | |
|---|--|
| <input type="checkbox"/> Angiogram | <input type="checkbox"/> Mammogram |
| <input type="checkbox"/> Arthroscopy | <input type="checkbox"/> MRI |
| <input type="checkbox"/> Biopsy | <input type="checkbox"/> Myelogram |
| <input type="checkbox"/> Blood tests | <input type="checkbox"/> NCV (nerve conduction velocity) |
| <input type="checkbox"/> Bone scan | <input type="checkbox"/> Pap smear |
| <input type="checkbox"/> Bronchoscopy | <input type="checkbox"/> Pulmonary function test |
| <input type="checkbox"/> CT scan | <input type="checkbox"/> Spinal tap |
| <input type="checkbox"/> Doppler ultrasound | <input type="checkbox"/> Stool tests |
| <input type="checkbox"/> Echocardiogram | <input type="checkbox"/> Stress test |
| <input type="checkbox"/> EEG (electroencephalogram) | <input type="checkbox"/> Urine tests |
| <input type="checkbox"/> EKG (electrocardiogram) | <input type="checkbox"/> X-rays |
| <input type="checkbox"/> EMG (electromyogram) | |

Are you seeing anyone else for the problem(s)?

(Check all that apply.)

- | | |
|--|---|
| <input type="checkbox"/> Acupuncturist | <input type="checkbox"/> Occupational therapist |
| <input type="checkbox"/> Cardiologist | <input type="checkbox"/> Orthopedist |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Osteopath |
| <input type="checkbox"/> Dentist | <input type="checkbox"/> Pediatrician |
| <input type="checkbox"/> Family practitioner | <input type="checkbox"/> Podiatrist |
| <input type="checkbox"/> Internist | <input type="checkbox"/> Primary Care Physician |
| <input type="checkbox"/> Massage therapist | <input type="checkbox"/> Rheumatologist |
| <input type="checkbox"/> Neurologist | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Obstetrician/Gynecologist | |

For Men:

Have you been diagnosed with prostate disease? Yes No

For Women:

Have you been diagnosed with:

Pelvic inflammatory disease? Yes No

Endometriosis? Yes No

Trouble with your period? Yes No

Complicated pregnancies or deliveries? Yes No

Other gynecological/obstetrical difficulties? Yes No

If yes, please describe: _____

Are you pregnant, or think you might

be pregnant? Yes No

12. Medications

Do you take any prescription medications? Yes No

If yes, please list: _____

Do you take any nonprescription medications?

(Check all that apply.)

- | | |
|---|---|
| <input type="checkbox"/> Advil/Alleve | <input type="checkbox"/> Herbal supplements |
| <input type="checkbox"/> Antacids | <input type="checkbox"/> Ibuprofen/Naproxen |
| <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Tylenol |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Decongestants | |

13. Functional Status/Activity Level

(Check all that apply.)

- Difficulty with locomotion/movement:
- bed mobility
 - transfers (such as moving from bed to chair, or from bed to commode)
 - gait (walking)
 - on level surfaces
 - on stairs
 - on ramps
 - on uneven terrain
- Difficulty with self-care (such as bathing, dressing, eating, toileting, etc.)
- Difficulty with home management such as household chores, shopping, driving/transportation, etc.)
- Difficulty with community and work activities/integration