PERFORM
Physical Therapy, PLLC

5 ½ Main Street, Suite 9
Delhi, NY 13753
Phone: (607)-386-1440

PATIENT INFORMATION			EMAIL address:	
First Name:	Last Name:			Middle Initial:
Address:		City:	State:	Zip:
Date of Birth:	Age:		Gender:	
Home Phone:			Alternate Phone:	
Chose Perform PT because: __Dr. __Insurance plan __Family __Friend __website __other social media __ Former patient __Other:				
WORK INFORMATION				
Employer:			Work phone:	
Occupation:	Status: __ full time __ part time __ retired __not employed			
CARE PROVIDER INFORMATION				
Referring provider name:			Referring provider phone:	
Primary care provider name:			Primary care provider phone:	
INSURANCE INFORMATION (Please bring your insurance card to your first visit)				
Primary Insurance Name:				
Subscriber's Name:			Subscriber's date of birth:	
ID #:			Group policy #:	
Patient relationship to subscriber: __ Self __ Spouse __ Child __ Other:				
Secondary Insurance Name:				
Subscriber's Name:	Subscriber's date of birth:			
ID #:	Group policy #:			
Patient relationship to subscriber: __ Self __ Spouse __ Child __ Other:				
AUTO OR WORK INJURY CLAIM (Please provide your insurance information as backup)				
Insurance Name: __ Auto			__Labor & Industries:	
Adjuster/Claim Manager:			Phone:	Ext:
Address:	City:		State:	Zip:
Claim #:	Accident date:		Cause:	
ATTORNEY INFORMATION				
Name:	Legal Firm:		Phone:	
Address:	City:	State:		Zip:
IN CASE OF EMERGENCY				
Name of Emergency Contact:			Relationship to patient:	
Home phone:		Work phone:		

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Medical History Form

Patient Name: _____ Height:_____ Weight: _____

Past/Present Medical Conditions (Circle YES or NO)					
Asthma	YES	NO	Heart Attack	YES	NO
Arthritis	YES	NO	Heart Disease	YES	NO
Cancer	YES	NO	Hernia	YES	NO
Chemical Dependency	YES	NO	High Blood Pressure	YES	NO
Circulatory Disease	YES	NO	Kidney Disease	YES	NO
Depression	YES	NO	Metal/Other Implant	YES	NO
Diabetes	YES	NO	Multiple Sclerosis	YES	NO
Dizziness	YES	NO	Nervous Disorder	YES	NO
Eating disorder	YES	NO	Numbness	YES	NO
Emphysema	YES	NO	Osteoporosis	YES	NO
Epilepsy	YES	NO	Pregnancy	YES	NO
Fainting	YES	NO	Stroke	YES	NO
Fatigue	YES	NO	Thyroid Problems	YES	NO
Headaches	YES	NO	Tuberculosis	YES	NO
Hepatitis	YES	NO	High Cholesterol	YES	NO
Fever/Chills/Sweats	YES	NO	Night Pain	YES	NO
Shortness of Breath	YES	NO	Nausea/Vomiting	YES	NO
Dysuria	YES	NO	Bowel Dysfunction	YES	NO
Urinary Frequency Changes	YES	NO	Unexplained Weight Change	YES	NO

Any problems/hospitalizations in the past year? ____Yes ____No

If "yes", please specify: _____

_____

Surgical History: _____

_____

Medications currently taking: _____

_____

Exercise habits: ____None ____1-2x/week ____3-4x/week ____5+ times/week

Work Activity: ____ Sitting ____Standing ____Light ____Heavy

Stress level: ____ Low ____Medium ____High

Lifestyle habits: ____Coffee # cups/day:_____

____Alcohol # drinks/week:_____

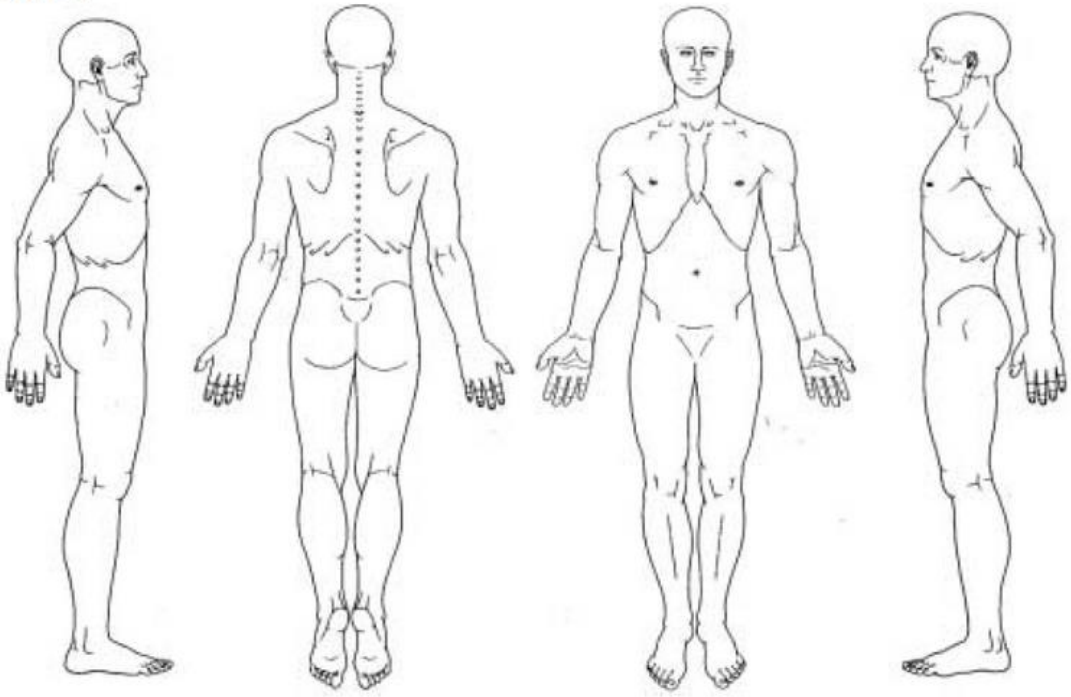
____Smoking # cigarettes/day: _____

Have you had physical therapy before? ___ Yes ___No When?_____

Chiropractor/Massage Therapy/Acupuncture? ____Yes ____No

PAIN OR SYMPTOM INTENSITY

Please mark an X to indicate the areas where you feel pain, swelling, numbness or discomfort. Describe what you feel or observe in your own words. Write anywhere in this area.



Rate the intensity of your pain or symptoms from 0 to 10 with "0" being none and "10" being worst:

How bad are your symptoms now? _____ / 10 How bad have they been in the past week? _____ / 10

What is the least pain in the past week? _____ / 10

Type of pain:

Burning	Shooting	Worst in AM
Sharp	Numbness/Tingling	Worst in PM
Dull/Achy	Constant	Worst at Night
Throbbing	Intermittent	

Other _____

Most painful activity? _____

Therapist Signature: _____ Date: _____

(By signing, therapist acknowledges reviewing medical history)

PATIENT SIGNATURE: _____

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Authorization for Emergency Medical Services

At any time while receiving services from Perform Physical Therapy and in the event of any medical emergency, I authorize Perform Physical Therapy or its employees/contractors to provide or obtain such medical treatment as they deem advisable under the circumstances, and I agree to assume sole responsibility for all charges for such treatment.

Release of Medical Records

I hereby consent and request that copies of my therapy treatment records be provided to the following for the period of my current start of care date to discharge date:

(Physician) _____

(Physician other) _____

(Family member) _____

I hereby consent and request that medical records, MRI reports, and any X-rays available to be released to Perform Physical Therapy from:

(name of facility)_____

(address of facility)_____

(phone)_____

I understand that all the information contained in these reports will be kept confidential and only will be provided to my physical therapist. I understand the information will be faxed or mailed to: Perform Physical Therapy, 5 ½ Main Street, Suite 9, Delhi, NY 13753.

Notice of Privacy Practices

I acknowledge that I have read copy of the Perform Physical Therapy Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Perform Physical Therapy and of my rights with respect to my health information. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

Patient Signature:_____ Date:_____

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Cancellation Policy

In the event of a cancellation or no-show without 24 hours' notice, Perform Physical Therapy reserves the right to charge you a $40 cancellation/no-show fee. This fee will not be covered by any insurance. Additionally, if you arrive late to your appointment by 20 minutes or more, you may be asked to reschedule your appointment to another time.

**PLEASE NOTE: If you are being treated under Workers' Compensation or No Fault, failure to attend Physical Therapy appointments may be viewed by the carrier as being non-compliant and could be considered grounds for a reduction in allowed benefits.

Thank you for your cooperation in this manner.

Please sign below to confirm you have been informed of our policy.

Patient Signature:_____ Date:_____

General Request for Service, Release of Information, Personal Effects, and Financial Authorization

1. I hereby voluntarily consent to such evaluation procedures and therapy and to such medical and diagnostic tests, as is necessary in the judgment of the Physical Therapist. I state that I have read and understand the following authorization and that I understand why the described treatment is necessary.
2. I hereby release Perform Physical Therapy from all liability resulting from loss or damage to any personal effects retained by me on arrival or received by me. This includes, but not limited to, jewelry, eyeglasses, electrical devices, clothing, and any other personal item(s).
3.

A. <u>Authorization for Release of Information by Perform Physical Therapy</u>

I hereby authorize and direct the above names facility, having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my treatment and medical care, all information needed to substantiate payment for such treatment and medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

B. <u>Assignment to Perform Physical Therapy</u>

I hereby irrevocably assign, transfer, and set over to the above-named facility sufficient monies and/or benefit to which I may be entitled from governmental agencies, insurance carriers or others who are financially liable for my treatment and medical care to cover the costs of the care and treatment rendered to myself or my dependent in said facility.

C. <u>Guarantee of Payment to Perform Physical Therapy</u>

I request Perform Physical Therapy to furnish all services and treatments as may be recommended or directed by the patient's physician. I acknowledge receipt of the same, and I agree to pay charges therefore, based on rates in effect at your facility. I understand that services may not be covered under my insurance. I also understand that I may be liable for payment of services not covered under my insurance. ***NOTICE OF ADVICE: The notice of advice advises the patient that the treatment may not be covered by their specific health care plan or insurer without a referral. I understand that services may not be covered under my insurance. I also understand that I may be liable for payment of services not covered under my insurance and it is my responsibility to understand my physical therapy benefits, eligibility and coverage**.

D. <u>For Patients Entitled to Medicare Benefits</u>

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for therapy services to Perform Physical Therapy or authorize such entity or corporation to submit a claim to Medicare for payment to me.

E. I have been provided with a copy of this document to retain for my future reference.

4. I have read the above certifications, or they have been read to me and I fully understand them.

_____	_____	_____
Patient Signature (Parent or Guardian if Minor) or Authorized Representative	Date/Time	Perform PT Representative