

PERFORM!

PHYSICAL THERAPY & PILATES

RELEASE OF INFORMATION:

The above Physical Therapy Center may disclose or request all or any part of the patient's records to any person or corporation which is or may be liable under a contract to the facility or the patient or to a family member of employer of the patient for all or part of the facility's charge, including, but not limited to, physical therapy services, insurance companies, Workman's Compensation/No fault carriers, welfare funds, or the patient's employers or any New York State or Federal agency per current rules and regulations. The Physical Therapy Center has the authority to reject any unreasonable request by an office or institution if such request might violate the patient's right to privacy.

RELEASE OF SIGNATURE:

I, _____ hereby authorize Perform! Physical Therapy & Pilates PLLC. via

E-signature, to bill _____, my insurance Company, on my behalf, and to furnish any medical information requested concerning my condition or treatment.

ASSIGNMENT OF BENEFITS:

I hereby assign, and set forth to the above Physical Therapy Center, sufficient monies and /or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my medical care to cover the costs of the care and treatment rendered to me or my dependent. I understand I am financially responsible to the above Physical Therapy Center for charges not covered by this authorization.

DIRECT ACCESS:

I understand that the therapist practicing under direct access are required to give notice of advice that insurance may not cover services when rendered without a physician referral.

PRIVACY PRACTICES ACKNOWLEDGEMENT:

I have received the Notice of Privacy and I have been provided an opportunity to review it.

APPOINTMENT CANCELLATION/NO SHOW POLICY:

Perform Physical Therapy and Pilates is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen. Please call us at (516)-992-2282 a minimum of 24 hours prior to your scheduled appointment to notify us of any changes or cancellations. If prior notification is not given, you may be charged **\$25.00** for the missed appointment. Thank you!

Print Name

Signature of Patient or Responsible Party

Date



PHYSICAL THERAPY & PILATES

WORKMAN'S COMP INFO:

Patient's Name: _____

Address: _____

Case#: _____

DOB: _____

DOA: _____

Location of accident: Address: _____

Insurance info: _____

Address: _____

Phone #: _____ Fax: _____

Employer: _____

Address: _____

Phone #: _____

Case Manager: _____

Phone #: _____

Fax #: _____

Doctor: _____

Address: _____

Phone #: _____

Fax #: _____

2421 Long Beach Road
Oceanside, New York 11572
Ph: 516-992-2282
Fax: 516-415-7604

performptny@gmail.com

Patient Information:

Patient Name: _____ DOB: _____ Marital Status: M S

Emergency Contact: _____ Relationship: _____

Phone: _____

If Patient is Minor, Name of Guarantor: _____

How Did You Hear About Our Office? _____

Primary Care Doctor: _____ City: _____ State: _____

Phone #: _____

Chief Complaint: Injured or Painful body part(s): If bilateral, check both and circle the side which is worse.

Shoulder	Upper Arm	Elbow	Forearm	Wrist	Hand	Finger(s)	Hip	Thigh
R L	R L	R L	R L	R L	R L	R L	R L	R L
Knee	Calf	Ankle	Foot	Toe(s)				
R L	R L	R L	R L	R L				

Do You Have: Pain Weakness Numbness Stiffness

Other (Please Explain): _____

Pain Scale (0 – 10): 0 1 2 3 4 5 6 7 8 9 10 (Past Week) **WORST:** _____ **BEST:** _____ **CURRENT:** _____

Date Symptoms started: _____

Where did the injury occur?

Work Home Auto Sports Other

Where you seen in the ER? Yes No

Any prior injuries or problem to same body part? Yes No Describe: _____

Describe in your own words how/when/where/ this injury occurred: _____

Medical History:

- | | |
|--|--|
| <input type="checkbox"/> Alzheimer's/Dementia | <input type="checkbox"/> History of Cancer:
(Type)_____ |
| <input type="checkbox"/> Cardiovascular Disease/Hypertension | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Cauda Equina Syndrome | <input type="checkbox"/> Immunosuppression |
| <input type="checkbox"/> Cerebral Vascular Accident | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Current Infection | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Diabetes Mellitus (Type): _____ | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Fracture or Suspected Fracture | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Traumatic Brain Injury |
| <input type="checkbox"/> Other (enter description below) | |
-

Surgical History: (Please List): _____

Allergies: _____

Current Medications: (Include Dosages)

Prescription: _____

Over the Counter _____

Herbals _____

Vitamin/Mineral/Dietary Supplements: _____

Not currently taking any medications