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

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)	Head	Neck	Upper Back	Lower Back
R L	R L	R L	R L	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: ___________________________________

____

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Medical History:

- ☐ Alzheimer's/Dementia
- ☐ Cardiovascular Disease/Hypertension
- ☐ Cauda Equina Syndrome
- ☐ Cerebral Vascular Accident
- ☐ Current Infection
- ☐ Diabetes Mellitus (Type): ________
- ☐ COPD/Emphysema
- ☐ Fibromyalgia
- ☐ Fracture or Suspected Fracture
- ☐ Depression/Anxiety
- ☐ Other (enter description below)

____

- ☐ History of Cancer: (Type)___________________
- ☐ Pacemaker
- ☐ Immunosuppression
- ☐ Lupus
- ☐ Muscular Dystrophy
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Parkinson's
- ☐ Rheumatoid Arthritis
- ☐ Traumatic Brain Injury

Surgical History: (Please List): ____

Allergies:______________________________

Current Medications: (Include Dosages)

☐ Prescription: ____

____

☐ Over the Counter____

☐ Herbals____

☐ Vitamin/Mineral/Dietary Supplements: ____________________________________ ☐

☐ Not currently taking any medications