Mountain Physical Therapy

427 Broadway Suite 3
Monticello, NY 12701
845-796-2470

PATIENT REGISTRATION

PATIENT INFORMATION

Name (Last, First, Middle)	SSN:	DOB:	Sex: Male or Female
Local Address	P.O. Box		
City, State, Zip	City, State, Zip		
Vacation or Away Address	City, State, Zip		

Home Phone	Cell Phone	Work/Alternative Phone
Marital Status	Race	Language
Emergency Contact Name and Phone		
Any custom or belief that might affect care?		

Employment Status: **Circle One** Part Time / Full Time / Unemployed / Retired / Student	Employer/Address
How did you hear about our services?	

Primary Care Doctor	Primary Care Phone #	Primary Care Address

PHYSICAL THERAPY CONTRACT

1. I will contact Mountain Physical Therapy **24hrs** before my appointment for any cancellation of a physical therapy appointment.
2. There will be a **$15** out of pocket charge if there is not a notice for a cancellation or NO SHOW.
3. I will arrive on time for my appointments.
4. If I miss 3 consecutive appointments without any notice Mountain Physical Therapy has the right to cancel the rest of my sessions.
5. Co payments are due at the time of the appointment.
6. I know that I am responsible if I am late for an appointment and therefore would have to wait.
7. Cell Phones must be OFF or silent the entire time you are in the office.
8. If you have children with you they must be supervised at all time.

X_____ _____

Signature of Patient/ Guardian — Date

PRIMARY INSURANCE	
Name of Insurance Company	Address and Phone # of Insurance
Policy # or Member #	Group #
Relationship to Insured: **(Circle One)** Self / Spouse / Child / Other	
Name of Policy Holder	DOB of Policy Holder

SECONDARY INSURANCE	
Name of Insurance Company	Address and Phone # of Insurance
Policy # or Member #	Group #
Relationship to Insured: **(Circle One)** Self / Spouse / Child / Other	
Name of Policy Holder	DOB of Policy Holder

WORKERS' COMPENSATION INFORMATION	
Did the injury occur while you were at work? **(Circle One)** Yes/ No	Date of Injury
Have you filed a report of your injury with your employer? **(Circle One)** Yes/ NO	
Name of Employer	Employers Phone
Name of Insurance Carrier	Carrier Address
Carrier Case #	WCB # (workers' comp. case number)
Name of Adjuster	Adjusters Phone

NO FAULT INFORMATION	
Where did accident occur? (City/ State)	Date of Accident
Insurance Carrier	Insurance Carriers Address
Policy #	Claim #
Case Manager	Case Managers Phone #

If you currently have an attorney for this accident please list their name and phone number:

427 BROADWAY SUITE 3 ~ MONTICELLO, NY 12701 ~ PH: 845-796-2470 ~ FAX: 845-796-1420

Name of Patient: **Date:**

Mountain Physical Therapy

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Ph: (845)796-2470

PATIENT HIPAA AWARENESS

With my permission, Mountain Physical Therapy may use and disclose protected health information (PHI) about me to carry out treatment, payment and health operations (TPO). Please refer to Mountain Physical Therapy's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent (a copy is in the Waiting Room.) Mountain Physical Therapy reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Office Manager.

With my permission, the office of Mountain Physical Therapy may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care.

With my permission, the office of Mountain Physical Therapy may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Mountain Physical Therapy restrict how it uses or discloses my PHI to carry out TPO. However the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Mountain Physical Therapy to use and disclose my PHI for TPO.

Assignment of Benefits

With my permission, I authorize any holder of medical information about me to release to the Center for Medicare & Medicaid Services (or any insurance carrier) and it's agents any information needed to determine these benefits or benefits payable for related services.

I request that payment of authorized Medicare, Medicaid (or private insurance company) benefits be made on my behalf to Mountain Physical Therapy for any services furnished to me. It is understood that final determination of coverage cannot be guaranteed by Mountain Physical Therapy. Therefore, it is ultimately my responsibility to pay for any and all services denied by my insurance company and I will be responsible for payment of services if correct insurance information is not given at the time of service.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

I have read and/or filled out all of the above information and by the affixation of my signature below hereby agree to all of the above.

Signature of Patient or Legal Guardian *Print Name of Patient of Legal Guardian* *Date*

Patient Summary Form

PSF-750 (Rev: 7/1/2015)

Instructions
Please complete this form within the specified timeframe. All PSF submissions should be completed online at www.myoptumhealthphysicalhealth.com unless otherwise instructed.

Please review the Plan Summary for more information.

Patient Information

Patient name: Last | First | MI

○ Female ○ Male

Patient date of birth

Patient address | City | State | Zip code

Patient insurance ID# | Health plan | Group number

Referring physician (if applicable) | Date referral issued (if applicable) | Referral number (if applicable)

Provider Information

1. Name of the billing provider or facility (as it will appear on the claim form)

2. Federal tax ID(TIN) of entity in box #1

3. Name and credentials of the individual performing the service(s)

1 MD/DO 2 DC 3 PT 4 OT 5 Both PT and OT 6 Home Care 7 ATC 8 MT 9 Other ____

4. Alternate name (if any) of entity in box #1

5. NPI of entity in box #1

6. Phone number

7. Address of the billing provider or facility indicated in box #1

8. City

9. State

10. Zip code

Provider Completes This Section:

Date you want *THIS* submission to begin:

Patient Type

1. New to your office
2. Est'd, new injury
3. Est'd, new episode
4. Est'd, continuing care

Cause of Current Episode

1. Traumatic
2. Unspecified
3. Repetitive
4. Post-surgical →
5. Work related
6. Motor vehicle

Date of Surgery

Type of Surgery

1. ACL Reconstruction
2. Rotator Cuff/Labral Repair
3. Tendon Repair
4. Spinal Fusion
5. Joint Replacement
6. Other _____

Diagnosis (ICD codes)
Please ensure all digits are entered accurately

1°
2°
3°
4°

Nature of Condition

1. Initial onset (within last 3 months)
2. Recurrent (multiple episodes of < 3 months)
3. Chronic (continuous duration > 3 months)

DC ONLY
Anticipated CMT Level

○ 98940 ○ 98942 ○ 98941 ○ 98943

Current Functional Measure Score

Neck Index | DASH | (other FOM)

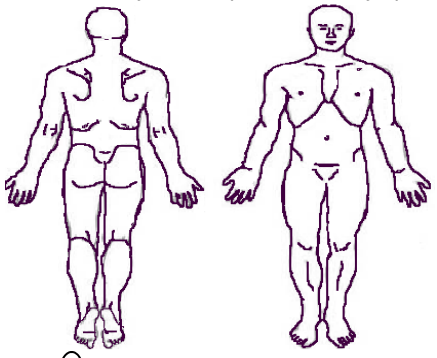
Back Index | LEFS

Patient Completes This Section:

(Please fill in selections completely)

Symptoms began on:

Indicate where you have pain or other symptoms:



1. Briefly describe your symptoms:

2. How did your symptoms start?

3. Average pain intensity:

Last 24 hours: **no pain** 0 1 2 3 4 5 6 7 8 9 10 **worst pain**

Past week: **no pain** 0 1 2 3 4 5 6 7 8 9 10 **worst pain**

4. How often do you experience your symptoms?

1. Constantly (76%-100% of the time)
2. Frequently (51%-75% of the time)
3. Occasionally (26% - 50% of the time)
4. Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)

1. Not at all
2. A little bit
3. Moderately
4. Quite a bit
5. Extremely

6. How is your condition changing, since care began at *this* facility?

0. **N/A — This is the initial visit**
1. Much worse
2. Worse
3. A little worse
4. No change
5. A little better
6. Better
7. Much better

7. In general, would you say your overall health right now is...

1. Excellent
2. Very good
3. Good
4. Fair
5. Poor

Patient Signature: X _____ **Date:** _____

OVERALL HEALTH

General Health Status □ Excellent □ Good □ Fair □ Poor

Do you Smoke?_____ If yes, how many cigarettes/packs a day?_____

If you smoked in the past, when did you quit?_____

Do you drink? _____ If yes, how many days a week do you drink?_____

Do you exercise beyond daily activities? Please explain. _____

Do you use a… □ Cane □Walker □ Wheelchair Other:_____

I live… □ Alone □With_____

MEN ONLY Have you ever been diagnosed with prostate diseases?_____

WOMEN ONLY Have you been diagnosed with any gynecological difficulties/disease?_____

Are you pregnant of think you might be pregnant? _____

FAMILY HISTORY

(Indicate what family member)

Heart Disease _____ Stroke_____ Cancer_____

Arthritis_____ Hypertension_____ Diabetes _____

Psychological _____ Osteoporosis _____ Other _____

MEDICAL HISTORY

□ Arthritis
□ Broken Bone
□ Osteoporosis
□ Blood Disorders
□ Circulatory/Vascular Problems
□ Heart Problems
□ High Blood Pressure
□ Kidney Problems
□ Multiple Sclerosis
□ Muscular Dystrophy
□ Parkinson's Disease
□ Seizures/ Epilepsy
□ Allergies
□ Developmental Growth Problems
□ Thyroid Problems
□ Skin Diseases
□ Lung Problems
□ Stroke
□ Diabetes/ High Blood Pressure
□ Low Blood Pressure
□ Head Injury
□ Ulcers/ Stomach Problems
□ Depression
□ Repeated Infections

Other:_____

Do you take any prescription medications? _____

Do you have difficulty with any of the following? □ Movement □ Self-Care □ Home Management

□ Difficulty with work/community integration

DO YOU HAVE A PACEMAKER? □ **YES** □ **NO**

SURGICAL HISTORY

Surgery	**Date**

CURRENT CONDITION(S)/ CHIEF COMPLAINTS

Describe what you're coming to therapy for?_____

When did this problem(s) begin? Month_____ Year_____

What makes the problem better?_____ What makes the problem worse?_____

What is your goal for physical therapy? _____

Have you had any clinical test done for this problem? *(example MRI/X-Ray?)* _____

If yes, when and what hospital?_____

Do you see any other specialists for this same problem? *(example a podiatrist, chiropractor, etc.)*

_____