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:**

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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*

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.)*

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