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NEW PATIENT INTAKE FORMS

Patient Information

Name:_____
FIRST MI LAST

Date of Birth: _____/_____/_____ Age: _____ Gender: ☐Male ☐Female ☐Other

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Address: _____
Number/Street City State ZIP Code

Email Address: _____ Cell: _____

Appointment Reminders: ☐Text ☐Voice Call ☐None

Emergency Contact Person: _____ Cell: _____
(Name and Relation)

How did you hear about us?

☐Google ☐Facebook/Instagram ☐Passed by Office ☐Employee Referral

☐Referring Doctor ☐Flyer ☐Other: _____

Private Insurance Information

Primary Insurance Carrier: _____ Member ID #: _____

Group Number: _____ Relation to insured: _____
(Self, Spouse, Child, Other…?)

Secondary Insurance Carrier: _____ Member ID #: _____

Group Number: _____ Relation to insured: _____
(Self, Spouse, Child, Other…?)

Having Secondary Insurance coverage does **NOT** guarantee that they will pick up remaining balances from the primary carrier and that you will not be liable for patient responsibility such as deductible, co-insurance or co-payment charges

Worker's Compensation and/or No-Fault Information (If not applicable, please skip)

Is this injury related to a New York State Worker's Compensation Claim or a Motor Vehicle Accident covered under No-Fault? (Check one) ☐Worker's Comp ☐No-Fault

Name of Insurance Carrier: _____

Date of Accident / Injury: _____ Claim Number: _____

Adjuster's Name: _____ Phone Number: _____

Did you get an attorney? ☐Yes ☐No

If Yes, please provide their information below:

Attorney's Name: _____

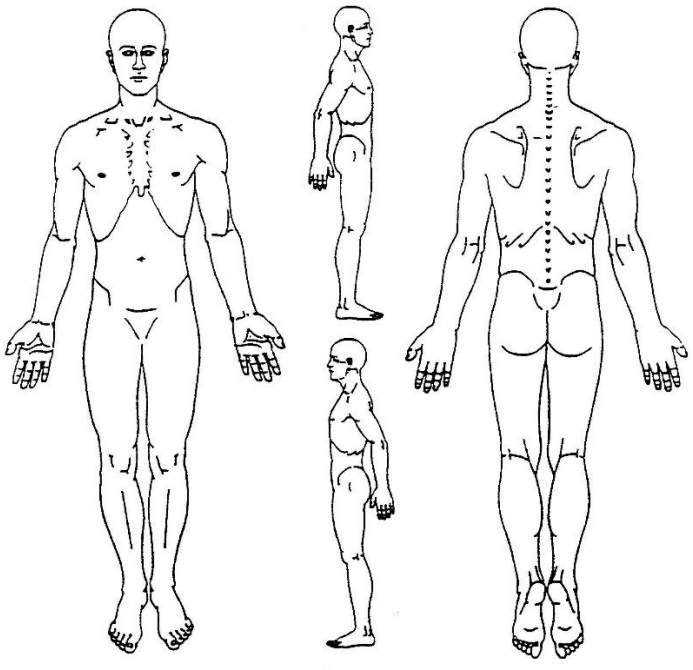
Name of Law Firm: _____

Address: _____
Number/Street City State ZIP Code

Phone #: _____ Fax Number: _____

Medical History

Please indicate where you have pain or other symptoms:



Medications:
Please list all over the counter prescription medications you are currently taking. Include dosage and frequency.

_____

_____

_____

Surgical History:
List any surgical procedures you have had and the dates they were performed.

_____

_____

_____

Diagnostic Testing:
Please check off any diagnostic testing and/or treatments you have had performed for this condition and/or injury.

☐ MRI ☐X-Ray ☐CT Scan

Allergies:

- ○ Congenital Heart Defect
- ○ Cancer
- ○ Heart Problems / Heart Disease
- ○ Joint Replacement/Repair
- ○ Joint/Tendon or Muscular Pain
- ○ Osteoporosis
- ○ Pacemaker
- ○ Psychological Issues
- ○ High or Low Blood Pressure
- ○ High or Low Blood Sugar
- ○ Chest Pain / Palpitations
- ○ High Cholesterol
- ○ Abdominal Pain / Bloating / Gas
- ○ Emphysema and/or Short of Breath
- ○ Poor Balance or Recent Falls
- ○ Coughing / Wheezing
- ○ Dizziness / Vertigo / Fainting
- ○ Gout
- ○ Severe Headaches
- ○ Rheumatoid Arthritis
- ○ Anemia / Epilepsy / Seizure Disorders
- ○ Circulation Problems / Blood Clots
- ○ Kidney Disease
- ○ STD / HIV / AIDs
- ○ Tuberculosis / Lung Disease
- ○ Thyroid Problems
- ○ Asthma / Bronchitis
- ○ Diabetes
- ○ Stroke
- ○ Lyme Disease
- ○ Painful Bowels / Loose Stool / Constipation
- ○ Multiple Sclerosis
- ○ Depression / Anxiety / Panic Attacks

Aquatic Therapy Screening (If not interested in going in the pool, please skip)

Be advised, our aquatic therapy program is an independent program. Meaning, at our facility, our Physical Therapist **DOES NOT** get into the pool with the patient. In addition, the patient must be able to independently enter and exit the pool as we do not have a hoyer or any patient lift equipment to assist with such task.

Please check off the below boxes if you suffer from any of the following:

- ○ Typhoid, Cholera, Dysentery, or any other waterborne disease
- ○ Fever higher than 100-degree Fahrenheit
- ○ Kidney Disease
- ○ Stomach or Intestinal Disorder
- ○ Infections Disease
- ○ Open Wounds
- ○ Skin Rashes
- ○ Perforated Ear Drums
- ○ Incontinence
- ○ Epilepsy
- ○ Radiation Treatment within the last 3 months
- ○ Difficulty breathing
- ○ High Blood Pressure or Heart Dis
- ○ ease
- ○ Pacemaker or Defibrillator

Furthermore, be advised that the pool at our facility has both a shallow and a deep end. Patients who are not able to swim are advised to stay where they can maintain their head above water.

I attest the above information is true and I understand my person risks associated with being in a pool and wish to proceed with aquatic therapy.

_____	_____	_____
Print Name	**Signature**	**Date**

Patient Financial Responsibility

It is your responsibility, as a policyholder, to confirm that the insurance information you are providing our facility with is your **primary insurance** carrier. It is also your responsibility to know your plan eligibility and benefits that you signed up for such as visitation limits, deductibles, co-payments, co-insurances and out of pocket information. Treatment that is Medically Necessary specific to your injury and diagnosis will be reimbursed to Long Island Premier PT based on our contractual agreement. Once treatment is no longer medically necessary, or you have reached your benefit maximum, services may be denied.

If your insurance carrier denies any or all of your medical claims, even if you are covered under another insurance company, you will be held solely responsible.

It is also your responsibility to provide to us your **secondary insurance** information if you have one. If you do not provide such information, you will be liable for the cost that would have been picked up by the secondary carrier.

Long Island Premier PT will provide the necessary clinical information upon request.

If your insurance company determines that services are no longer medically necessary, you will be billed $100.00 per visit for services that have been rendered.

I understand it is my responsibility to confirm my coverage with my insurance carrier and that Long Island Premier PT may verify such coverage as a courtesy to me. Long Island Premier PT will not be held responsible or liable for inaccurate information or denials provided by your insurance carrier after services have been rendered.

My signature below acknowledges that I have read and fully understand that:
1. Long Island Premier PT has discussed my benefits verified with the insurance carrier.
2. I have been informed of my financial responsibility if my insurance company denies all or part of these services as not medically necessary, or if a secondary insurance was not provided.
3. I fully accept the financial responsibility to pay for denied services at the time my insurance carrier deems my treatment not medically necessary.
4. I am ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. I am responsible for deductibles, co-payments, co-insurance amounts or any other patient responsibility indicated by your insurance carrier. I authorize payment to LI Premier Physical & Aquatic Therapy for all services rendered.

_____	_____	_____
Print Name	**Signature**	**Date**

Consent and Disclosures

CONSENT TO RELEASE INFORMATION TO FAMILY OR FRIENDS

With your consent, Long Island Premier Physical & Aquatic Therapy will discuss medical records or billing information to a spouse, family member, or other designated individual. Please note that you are waiving your right to patient confidentiality if consent is given.

Initial Here to give consent: _____

I am hereby giving my consent to Long Island Premier PT office staff to discuss my medical condition or billing concerns with the person/persons I have designated below:

Name: _____ Relation: _____

Name: _____ Relation: _____

INFORMED CONSENT TO TREAT

At Long Island Premier Physical & Aquatic Therapy /DBA/ Premier Performance Physical & Aquatic Therapy, we use a variety of procedures, manual therapy techniques, exercises, and other modalities to help us try to improve your functional status and quality of life.

Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain therapy modality or procedure. We are not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help your condition for which you are seeking treatment for. Though not expected, there is also a risk that the treatment you receive at our facility will cause you pain, injury and/or aggravate your condition.

You have the right to ask your physical therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms and testing results. You may also discuss with your physical therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time during your treatment session.

Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding what type of exercises you are performing and any specific risks associated with your exercise, your therapist will be glad to answer them.

AUTHORIZATION TO TREAT MINOR [Skip if not applicable]

I am aware my child will be receiving Physical Therapy treatment at Long Island Premier Physical & Aquatic Therapy. Please accept this form as my consent to treat my child: _____.

Parent/Guardians Signature: _____

Relation to Patient: _____

I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENTS AND DISCLOSURES.

_____ _____ _____

Print Name **Signature** **Date**

ATTENTION

Referrals and/or Prescriptions

Please check if your insurance carrier requires a referral from your primary care physician.

Referrals are patient responsibility and must be completed and turned in to Long Island Premier on time to avoid any insurance denials.

Verification of Benefits

Our office verifies patient benefits with your insurance carrier as a courtesy to the patient. Benefits quoted are not a guarantee of payment. Patient is ultimately responsible for any denied services rendered at our facility.

Notice of Direct Access (Skip if you have a prescription or referral for PT)

UNDER NY STATE LAW, A PATIENT CAN BE SEEN DIRECT ACCESS FOR 30 DAYS OR 10 VISITS, WHICHEVER COMES FIRST.

Direct access care allows us to treat a patient without a referral from the physician. We will verify patient's benefits at time of appointment, but are required to inform the patient that an insurance company may not reimburse for services without a referral. Please be aware of your plans policy on direct access.

IF THE PATIENT IS UNDER 18 YEARS OF AGE, A PARENT OR GUARDIAN MUST SIGN THIS FORM

Patient, Parent and/or Guardians Signature: _____

Relation to Patient: _____

Patient's Individual Rights

You have the right to inspect and ask for a copy of your personal health information at any time. You have the right to ask us to make changes or corrections in your information. The Practice does not have to comply with your request. You have the right to file a disagreement with the Privacy Officer.

You may request a list of all the disclosures that we have made of your PHI after April 14, 2003 for any reason other than for treatment, billing, or administrative activities of the practice.

You also have the right to ask in writing that the Practice not disclose your PHI except when authorized by you, required by law or in the case of an emergency. You may also request that your PHI is not disclosed to family members or friends that may be involved in your care. The Practice will consider all such request, but is not required to agree or act on them. You have the right to have confidential information sent to you at an alternative location or by a means other than the postal service.
You have the right to obtain a copy of this notice.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE PATIENT BILL OF RIGHTS

_____ _____ _____

Print Name **Signature** **Date**