MILLENNIUM PHYSICAL THERAPY

## A) PATIENT INTAKE/TREATMENT FORM

1) **Patient Name:** _____ 2) **Social Security #:** _____

3) **Home Phone number:** (____)_____, **Cell:** (____)_____, **Work:** (____)_____

4) **Address:** _____
**City, State, Zip Code**

5) **Gender: Male Female** 6) **Date of Birth (DOB):** ____/____/_____

7) **Marital Status: S:**_____ **M:** _____ **Other:** _____

8) **Emergency contact:**_____ **Relation:**_____ **Emergency #:**(_____)_____

## B) MAJOR MEDICAL INSURANCE INFORMATION:

1) **Health Insurance Name:** _____
(Please verify with secretary/front desk if there are any requirements needed to proceed with physical therapy treatment such as referrals or pre-certifications)

2) **Policy Holders Name:** _____ 3) **Policy holders DOB:** ____/____/_____

4) **Policy Holders Social Security #:** _____ 5) **Insurance ID#:** _____

*** If applicable please provide Secondary Insurance:**

1) **Health Insurance:** _____

2) **Policy Holders Name:** _____ 3) **Policy holders DOB:** ____/____/_____

4) **Policy Holders Social Security #:** _____ 5) **Insurance ID#:** _____

## C) Is this a Workers Compensation Case (WC)? YES ☐ NO ☐
## (If Not, skip to section D)

a. **Date of Accident:** _____/ _____/_____ b. **Carrier Name:** _____

b. **WCB #**_____ **and Case #:** _____

c. **Name of Adjuster:** _____ **Phone #:** _____

d. **Employer Name:** _____ **Phone #:** _____

- **Address:** _____ **Fax #:** _____

e. **Attorney Name:** _____ **Phone #:** _____

- **Address:** _____ **Fax #:** _____

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**D) Is this a No-Fault Case (NF)? YES ☐ NO ☐**
**(If Not, skip to section E)**

**f. Date of Accident: ____/____/_____** **b. Insurance Name: _____**

**g. NF Claim #_____ and Policy #: _____**

**h. Name of Adjuster: _____ Phone #: _____**

**i. Attorney Name: _____ Phone #:_____**

- **Address: _____ Fax #: _____**

**E) Referring MD: _____**

**1) Which Body Part(s) has your MD Prescribed Physical Therapy for? (Please Circle)**

**Neck Back L/R Shoulder L/R Elbow L/R Wrist L/R Hand L/R Knee L/R Ankle L/R Foot L/R Hip**

**Other: _____**

**2) Have you received prior Physical Therapy services for this problem *this year*?**

- ☐ **YES If Yes, describe frequency and duration of treatment: _____**
- ☐ **NO If No, Have you received Physical Therapy services *this year* for anything else? YES NO**

**3) Have you *ever* received Physical Therapy services? YES NO**

**F) How did you hear about us? (please circle)**

**Doctor Family Friend TV Ad Print Ad Website Other:_____**

**G) Please provide us with your Email Address so that we may send you our Monthly Newsletter: _____**

## Assignment & Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to **Millennium Physical Therapy, P.C** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize **Millennium Physical Therapy, P.C** to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

| _____ | _____ | _____ |
|---|---|---|
| Responsible Party Signature | Responsible Party Print Name | Date |

# PATIENT MEDICAL HISTORY

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**PLEASE MARK THE FOLLOWING IF YOU HAVE HAD:**

____ Angina
____ Heart Attacks
____ Stroke
____ Heart Surgery
____ Tumors
____ Diabetes
____ Epilepsy
____ Arthritis
____ Circulatory problems
____ Osteoporosis
____ Emotional Problems
____ Nervous Problems
____ Kidney Disease
____ Gout
____ Neck Injuries
____ Fractures (broken bones)
____ Dislocation (joints)
____ Back injuries
____ Whiplash
____ Heart Disease
____ Cancer
____ High blood pressure
____ Lung disease
____ Jaw injuries/TMJ
____ Gastrointestinal problems

**PLEASE MARK THE FOLLOWING IF YOU HAVE RECENTLY EXPERIENCED:**

____ Headaches
____ Falls
____ Tremors
____ Muscular pain at rest
____ Difficulty sleeping
____ Constant pain unrelieved by rest / movement
____ Dizziness
____ Balance problems
____ Unusual fatigue
____ Unusual weakness
____ Blurred/double vision
____ Unexplained weight loss
____ Shortness of breath
____ Tingling, numbness or loss of feeling
____ Pain with coughing/sneezing
____ Change in bowel and bladder habits
____ Unusual skin coloration

**PLEASE LIST ANY MAJOR SURGERIES AND HOSPITALIZATIONS**

_____ DATE:_____
_____ DATE:_____

**DO YOU SMOKE?** YES / NO. **ARE YOU PREGNANT?** YES / NO **ALLERGIES** YES/ NO _____

**PLEASE LIST ALL MEDICATIONS YOU ARE PRESENTLY TAKING:**

_____

_____

**PLEASE MARK THE FOLLOWING IF ANY OF THESE DIAGNOSTIC TESTS HAVE BEEN PERFORMED?**

____ X-RAYS DATE:_____ RESULTS:_____
____ MRI DATE:_____ RESULTS:_____
____ EMG/NCV DATE:_____ RESULTS:_____

**Please Describe Your Problem:** _____ **Date of Onset:** _____

_____

**How did your symptoms begin?** _____

_____

**1. PAIN: Please Rate Your Pain from 0-10: 0 ____ 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ 7 ____ 8 ____ 9 ____ 10 ____**

**Do you have a history of falls within the past year? YES / NO If so, how many?** _____

**PLEASE CHECK THE FOLLOWING WHICH BEST DESCRIBE YOUR PAIN**

____ CONSTANT
____ INTERMITTENT
____ PAIN UPON WAKING
____ INCREASING
____ DECREASING
____ OCCASIONAL
____ NIGHT PAIN
____ STIFFNESS
____ STATIC
____ DULL/ACHY PAIN
____ SHARP PAIN

PAIN IS **AGGRAVATED** BY:_____
PAIN IS **EASED** BY:_____

**2. How would you rate your ability to perform routine daily activities:**
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

**3. How would you rate your ability to perform the activities associated with your job:**
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

**4. How many days since your current injury?** ☐ 0-30 days ☐ 31-90 days ☐ 90+ days

**I _____ have provided all of the above information to the best of my knowledge at the time of this visit and will notify this office if any information above has changed during the care of Millennium Physical Therapy.**

Signature: _____ Date: _____

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Dear Patient,

Welcome to our practice. Thank you for your confidence and trust in scheduling an appointment with our clinic. We are always dedicated to quality care for all our patients and we are always here to discuss your problems and find together the most appropriate solution. Our office patient policies are as follows. Please read carefully the following policies and sign below.

# GENERAL OFFICE POLICIES

1) We require 24 hours notice in the event of a cancellation. It is your responsibility, when you call in ***to have an alternative time in mind that will ensure you get in the full prescribed number of treatments that week whenever possible.***
2) There is a **$50.00** charge for a cancellation without proper notice. This charge will probably not be covered by your insurance company, but will have to be paid by you personally.
3) You should understand that when you no-show, three people get hurt: 1) yourself because you don't get the treatment you need as prescribed by the doctor and our staff, 2) the therapist who now has a "vacancy" in their schedule since the time was reserved for you personally, and 3) another patient who could have been given treatment if you had given us proper notice.
4) **Regarding Lateness:** If you are late, you may not get in your full treatment because it would mean other patients are delayed.
5) **Regarding Being Early:** Most of the time you'll have to wait until your scheduled time to be seen because there are other patients who are still in treatment.
6) For your health's benefit we have developed both a formal evaluation process and a discharge process. In each of these, the Physical Therapist prepares a report for your doctor.
7) Please understand that your insurance policy is a contract between you and your insurance company. While we may accept your insurance as payment, your contract with us is a separate agreement. In other words, if your insurance refuses to cover a certain treatment or otherwise fails to pay us, your contract with us still exists, and you are responsible for payment personally.
8) ***Co-pays, deductibles, and payments*** if you are a self-pay patient, are due at the time of service. We accept payments by credit card, check, cash or money order **only.**
9) We will allow, on special occasions, a long term payment plan budgeted on the individual according to need. In any event, if you request such a plan, you will sign a written agreement which must be given final approval by the Clinical Director.
10) If at any point you have a problem regarding billing and payment, talk to our secretary and they will arrange for you to see our office manager.

***After you have read carefully the above, please sign the following:***

I _____, agree to be treated in this Physical Therapy clinic by the Physical Therapist and their staff and I also agree with the terms specified above.

_____ **Date**

_____

**Patient's Signature**

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**State Of New York**

**WORKERS' COMPENSATION BOARD**

**CLAIMAINT'S AUTHORIZATION TO DISLCOSE WORKERS' COMPENSATION RECORDS**

(Pursuant to Workers' Compensation Law Section 110-a)

| Claimant's Name | Claimant's Social Secury No. | Claimant's Current or Most recent WCB case No. If any | Date of Accident for this case |
|---|---|---|---|
| | | | |

| If Release Is Authorized For Additional Case Files, Check One Box | Records Authorized for Release |
|---|---|
| ☐ Any and All Other Cases For This Claimant<br>☐ Individual Claimant Case Files I dentified below ( give WCB Case No. and date of accident for each) | ☐ Entire File (s)<br>☐ Specific Document(s)- give details below |

| Reason for Disclosure of Records (optional) |
|---|
| |

**INSTRUCTIONS:**
**Submit original to the Workers' Compensation Board and retain a copy of your records. Authorization for disclosure of records for certain purposes is not valid under the law. See excerpt of WCL Section 110-a on the reverse of this form. The authroization is effective until it is revoked by the claimant. Claimant nay revoke this authorization at any time, upon written notive to the Workers' Compensation Boards.**

**THIS AUTHORIZATION DOES NOT PERMIT eCASE ACCESS**

Pursuant to Section 110-a of the Workers' Compensation Law I, _____ represent that I' am a
claimants' name
person who is/was the subject of the Workers' Compensation case(s) indicate above, and I authorize the Workers' Compensation Board to discuss the above- referenced Workers' Compensation Board records with and/or release a copy of the above- referenced records to

_____at

**NAME**

_____ I

**ADDRESS**

Understand that the requesting party may be required to pay a statutory fee prior to being provided copies of these records by the Worker's Compensation Board.

_____ _____

**CLAIMANT'S SIGNATURE (ink only)** **DATE**

Failure to provide the information requested on this form will not result in the denial of your authorization, but may delay the processing of your request. The voluntary release of your social security number enables the Board to ensure that information is associated with, and quick action is taken on your request.

# CONSENT TO USE /DISCLOSE

# HEALTH INFORMATION FORM

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Although Millennium is not required by law to obtain a signed consent from you for treatment, payment or healthcare operation purposes, we encourage you to sign this consent so that you are aware of our practices regarding protection of your personal health information.

Should you desire a more complete description of the permissible uses and disclosures of your protected health information, you have the right to review a Notice of Privacy Practices (the "Notice") prior to signing this consent.

The Notice is available by contacting the Privacy Officer. Please note that Millennium reserves the right to change the privacy practices described in the Notice. Should you wish to obtain a revised Notice, please contact the Privacy Officer.

By signing this consent, you agree that Millennium may use or disclose your protected health information to carry out treatment, payment, or health care operations.

You have the right to request that Millennium restrict how your protected health information is used or disclosed to carry out treatment, payment, or health care operations. However Millennium is not required to agree to such restrictions. If Millennium does agree to a restriction that you request, such restriction will be binding.

You have the right to revoke this consent in writing, except to the extent that Millennium has taken action in reliance to your consent.

Acknowledgment and Agreement:
I consent to Millennium sending protected health information to the insured in the event I am receiving treatment but am not insured under my insurance policy. Such information may include, but not being limited to, explanation of benefits ("EOB") or invoices regarding my treatment. I understand that if I do not want such protected health information mailed to the insured, then I will notify Millennium of my objectives and will complete a request for Restriction of use and Disclosure form.

In addition, I understand and accept the risk of unintentional disclosure of my protected health information because the treatment area is an open area where I and other patients are treated simultaneously I understand that none of my protected health information may be inadvertently overheard by other patients and/or therapists. I also agree not to disclose any protected health information that I might inadvertently overhear about other patients while I am receiving treatment in the open treatment area.

I consent to Millennium releasing my protected health information to the following individuals.

**Name:**_____ **Relationship to patient:**_____

**Name:**_____ **Relationship to patient:**_____

I have received a copy of Millennium Physical Therapy's Notice of Privacy Protection.

I hereby notify that I have read the provisions set forth in this consent. I understand and agree to the terms of this consent.

**Patient's name:**_____ **Date:**_____

**Signature of Patient or Representative:**_____

**Name of Representative**:_____ **Relationship to patient**:_____

**FOR OFFICE USE ONLY:**

_____ **ACCEPTED ON** _____ _____ **INPUTTED DATA ON** _____ _____ **VERIFIED INSURANCE ON** _____