PROVIDENT
PHYSICAL THERAPY
& REHABILITATION
Exceptional Care, Outstanding Results

Name: _____
Last First Middle

Birthdate: ____/____/_____ Age: _____ Sex ☐ F ☐ M

Address:
_____
_____

Appointment Reminders:

☐ Email E-mail address: _____

☐ Text Message Cell Phone #: _____

Provider: ☐ Verizon ☐ AT&T ☐ Sprint ☐ T-Mobile ☐ Other_____

How did you hear about this clinic?

Reason for PHYSICAL THERAPY? (include body part and indicate right or left)

Describe briefly your present symptoms:

Have you ever had a similar problem? ☐ Yes ☐ No How long ago? _____

Pain Scale (0-10 level) With 0 being the lowest and 10 the highest: _____

Date that Injury Began? _____

Has the problem been ☐ Chronic (6weks or more) ☐ Subacute(2-6 week ☐ Acute (less than 2 weeks)

What makes symptoms better? _____

What makes symptoms worse? _____

X-RAY or MRI ☐ Yes ☐ No Date of Exam: _____

Where performed? _____ Phone number: _____

For this injury, did you have surgery? ☐ Yes ☐ No Date of surgery: _____

Hospital/ Surgical Site Name: _____

Would say your health is ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Exercise Habits: _____

Are you pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

What is it TODAY that you can't do in your daily activities that you used to do?

1. _____

2. _____

3. _____

4. _____

5. _____

Drug allergies: ☐ No ☐ Yes If yes, to what? _____

Medications: Please list all medications that you currently take. Include non-prescription medications & vitamins/ supplements **OR** provide medication list if available

Name of drug	dosage and frequency

MEDICAL HISTORY

Have you ever had any of the following listed below?

- ☐ NONE
- ☐ Diabetes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hypothyroidism
- ☐ Goiter
- ☐ Cancer (type) _____
- ☐ Leukemia
- ☐ Psoriasis
- ☐ Angina
- ☐ Heart problems
- ☐ Heart murmur
- ☐ Pneumonia
- ☐ Pulmonary embolism
- ☐ Asthma
- ☐ Emphysema
- ☐ Stroke
- ☐ Epilepsy (seizures)
- ☐ Cataracts
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Crohn's disease
- ☐ Colitis
- ☐ Anemia
- ☐ Jaundice
- ☐ Hepatitis
- ☐ Stomach/peptic ulcer
- ☐ Rheumatic fever
- ☐ Tuberculosis
- ☐ HIV/AIDS
- ☐ Other_____

ADDITIONAL INFORMATION

Referring Doctor: _____

Address: _____

Phone Number: _____

Primary Care Doctor: _____

Address: _____

Phone Number: _____

Emergency Contact: _____

Phone Number: _____

Relationship: _____

For Medicare Patients only:

Have you been seen by OR are you currently being seen by a Home Health Care Agency? ☐ Yes ☐ No

If yes, when? _____

Patient Signature: _____ Date: _____

Informed Consent for Physical Therapy

Dear Patient:

Physical therapy involves the use of many different types of physical evaluation and treatment. At *Provident Physical Therapy* we use a variety of procedures and modalities to help us to try and improve your function. As with all forms of medical treatment, there are benefits and risks with physical therapy.

Since the physical response to a specific treatment can vary wide 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 the condition you are seeking treatment for. There is also a risk that your treatment may cause pain or injury, or may aggravate previously existing conditions.

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 therapist what the potential risks and benefits of a specific treatment may be. You have the right to decline any portion of your treatment at any time before or 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 the type of exercise you are performing and any specific risks associated with your exercise, your therapist will be glad to answer them.

I acknowledge that my treatment program has been explained by a therapist at Provident Physical Therapy, and all of my questions have been answered to my satisfaction, I understand the risks associated with a program of Physical Therapy as outlined to me, and I wish to proceed.

_____	_____	_____
Date	Patient Name	Patient Signature

If Patient listed is a Minor:

_____
Parent/ Legal Guardian/ Representative Name

_____
Parent/ Legal Guardian/ Representative Signature

_____
Relationship to Patient

Provident Physical Therapy
554 Larkfield Road, Suite 207
East Northport, NY 11731

Authorization for use of Signature on File for Claim Authorization

_____ _____
Insurance Plan Policy ID#

I, _____, authorize Provident Physical Therapy & Rehab/Provident Physical and Occupational Therapy, PLLC to mark the section "Enrollee or Authorization Person's Signature" with the notation "Signature on file".

This section authorizes:

1. The release of any medical information necessary to process this claim.
2. Payment of medical benefits to the undersigned physicians or supplier of services.
3. This authorization will remain in force until terminated in writing by the enrollee.

_____ _____
Patient's Signature Date

_____ _____
Parent / Guardian Signature Relationship to patient

- If the patient is unable to sign, a representative's signature is required; indication of the relationship to the patient as well as reason unable to sign. If the patient is under the age of 18, a parent or guardian must sign.
- If the patient does not have a representative present, verbal consent may be obtained and the medical personnel obtaining the consent may sign.

Provident Physical Therapy

Designated Individuals Authorization Form

I hereby authorize one or all the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information. If you do not authorize any parties below, please "x" through section below.

Patient Name:_____

Authorized Designees:

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Acknowledgement of Notice of Privacy Practices

Provident Physical Therapy reserves the right to modify the privacy practices outlined in the notice.

( ) I have received a copy of the notice of privacy practices for Provident Physical Therapy.

Cancellation Policy

To serve our patients best, we have instituted a cancellation policy. We require 24-hour notice for cancellations. As a courtesy, reminder email/ text messages are sent 1 day prior to your appointment to allow you contact us in the event you need to cancel or reschedule your appointment. If an appointment is missed, cancelled, or rescheduled without 24-hour notice there will be a $25.00 fee billed to the patient.

☐ I acknowledge that I have been notified of the cancellation policy.

Electrical Stim Pads Policy

To ensure the highest level of infection control. We are requiring each patient to purchase their own set of electrical stimulation pads. **The cost for a set is $5.00** and they will be stored at our office in an individually sealed bag and labeled with your name. Once therapy is completed, they will be filed to your chart for future use. ***Staff:*** Paid (please check) _____

_____ _____

Signature of Patient Date

(Required if the patient is under the age of 18 or an adult who is unable to sign this form)

_____

Signature of Patient Representative

_____

Relationship to Patient