

W S P T

PHYSICAL THERAPY  
AQUATIC THERAPY • WELLNESS

WORLD CLASS CARE RIGHT AROUND THE CORNER

## PATIENT INFORMATION

NAME: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_ AGE: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ EMERGENCY CONTACT PHONE #: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_ SOCIAL SEC. #: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

Date of Onset: Injury/problem/surgery: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Have you ever had/received physical therapy? \_\_\_\_\_

DO YOU HAVE NOW, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING? **PLACE A CHECK MARK FOR YES**

DIABETES	___	ALLERGIES	___
HIGH BLOOD PRESSURE	___	PREVIOUS SURGERIES	___
PACEMAKER	___	CIRCULATORY DISEASE	___
CHRONIC HEADACHES	___	METAL IMPLANTS	___
KIDNEY PROBLEMS	___	DIZZINESS	___
SEIZURES	___	CANCER	___
HERNIA	___	CURRENTLY PREGNANT	___
BLADDER PROBLEMS	___	OSTEOPOROSIS	___
BOWEL PROBLEMS	___	FRACTURES	___
PINS AND NEEDLES	___	RECENT WEIGHT LOSS	___
NERVOUS DISORDER	___	PROBLEMS WITH BOTH ARMS OR BOTH LEGS AT THE SAME TIME	___

Are you presently taking any medications? \_\_\_YES \_\_\_NO

If YES, please list your medications and for what conditions OR **attach a list**:

Have you had any x-rays, CAT scan, MRI's, or other diagnostic tests for your recent order? \_\_\_YES \_\_\_NO

If YES, please explain the findings as you understand them:

Is there anything else you think we should know about your general health, or current condition? Please explain and if, necessary, we can talk about it:

PHYSICAL THERAPIST SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



## PATIENT FINANCIAL RESPONSIBILITY

Realizing that financial surprises can be unpleasant, we wish to provide you with the following information concerning your financial responsibility for the services that you receive from WSPT.

If your insurance policy requires a referral from your Primary Care Physician (PCP), it is your responsibility to obtain that referral. We are happy to assist you in obtaining referrals, however, the responsibility is ultimately yours.

Payment is requested at the time of service for any amounts which will be applied to copay, deductible or coinsurance. In addition, some services or supplies may not be covered by your insurance. Payment for these items will be requested at the time of service.

Please inform us of any insurance changes. Failure to provide current insurance information may result in a denial of claims which could then become your responsibility. Please keep in mind that many insurance carriers have a claim filing deadline, sometimes as short as 60 days.

**Cancellations must be made more than 24 hrs in advance of scheduled appointment. A charge of \$45 will be incurred for late notice (less than 24hrs) and/or same-day cancellations. If you no-show three appointments in one month you may be discharged and forfeit future appointments. Please note there is an answering machine during after business hours for your convenience.**

NAME OF BENEFICIARY (PATIENT): \_\_\_\_\_

HIC OR ID NUMBER: \_\_\_\_\_

I request that payment of authorized Medicare or other insurance benefits be made on my behalf to WSPT for any services furnished me by WSPT. I authorize any holder of medical information about me to release to my insurance carrier or to the Centers for Medicare Services (CMS) or its agents any information needed to determine these benefits or the benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier. For all managed care plans (HMO, PPO, POS, EPO or other), I understand that I will be responsible for the copay, deductible and coinsurance as governed by the managed care contract, as well as for any services deemed non-covered.

BENEFICIARY (PATIENT) SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_



## **PRIVACY DISCLAIMER**

In providing services to you, we create and store health information that identifies you. We understand that this information about you and your health is personal, and we are committed to protecting the privacy of this information. We must obtain your one-time consent before services are rendered.

### **REVOKING CONSENT**

You have the right to revoke this consent at any time, except to the extent that the office has already taken action based upon your consent. For example, if you revoke your consent after the office has provided treatment, the office is permitted to use or disclose your health information to bill for that treatment. To revoke this consent, please send a written request to our office.

### **SCOPE OF CONSENT**

By signing this form, I hereby consent that my information is correct and authorize Westchester Square Physical Therapy (WSPT), PC and its providers to use and disclose my personal health information, as necessary, for the purposes of obtaining medical treatment, facilitating payment of services rendered, and for normal business.

### **USE OF IMAGES**

For valuable consideration received, I hereby grant to Westchester Square Physical Therapy and his/her legal representatives and assigns, the irrevocable and unrestricted right to use and publish photographs and footage of me, or in which I may be included, for editorial, same without restriction: and to copyright the same. I hereby release Photographer and his/her legal representatives and assigns from all claims and liability relating to said photographs.

### **VIDEO SURVEILLANCE**

WSPT believes that safeguarding the personal welfare of its patients and employees is of paramount importance. In an effort to discourage those behaviors which threaten personal safety or a potential loss, selective use of video surveillance is engaged at our office. Areas under surveillance include, but are not limited to, waiting room, gym floor, and corridors. WSPT respects the privacy of its patients and employees and works diligently to balance that privacy against safety needs

PATIENT OR REPRESENTATIVE SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_