Health. Wellness. Results.
Patient Information

Northern PHYSICAL THERAPY & Fitness
www.nptny.com

Patient Missed Appointment Policy & Acknowledgement of Privacy Practices

We strive to provide our patients with the utmost professionalism, excellence of service and the guarantee of privacy as mandated by section 164.520 of the HIPAA Privacy Rule (copy located at the front desk). Our commitment to your well-being and gain of your physical abilities is something everyone in our clinic takes quite seriously.

We expect you to keep all your appointments. We will provide you with a printout of your appointment dates and times. We reserve the right to discontinue care and will inform your physician that your services have been discontinued due to non-compliance with the prescribed rehabilitation order.

If you need to re-schedule an appointment we require a 24-hour notice. This should be in the same week, preferably the very next day.

We reserve the right to charge a $25 fee for missing a scheduled appointment without a 24-hour notice. (Your insurance carrier will NOT be liable for this charge).

Release of Information & Authorizations

The undersigned authorizes & directs Northern Physical Therapy, PLLC, having treated the patient to release to governmental agencies, insurance carriers, or others who are financially liable for my physical therapy treatment, any medical record or other information pertinent to my physical therapy treatment.

I am responsible for all financial obligations of health services for the above patient, for reimbursement and payment of all claims from my insurance company. I authorize the insurance carrier to pay Northern Physical Therapy directly, in accordance with the New York State prompt pay law for these services. If for any reason the account should become delinquent, I agree to pay all rebilling charges, interest charges, collection costs, and reasonable legal fees incurred in collection of this account.

X_____ _____

Signature of patient or responsible party — Date

Northern Physical Therapy, PLLC

203 State Street
Ogdensburg, New York 13669
Phone: (315)393-2024
Fax: (315)393-2025

26908 Independence Way
Leray Medical Center
Evans Mills, New York 13637
Phone: (315) 629-6255
Fax: (315) 629-6254

307 Riverside Drive
Clayton, New York 13624
Phone: (315) 686-1757
Fax: (315) 686-1758

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Northern Physical Therapy, PLLC

The Patient is responsible to obtain prior authorization for Physical Therapy from Insurance. The patient is responsible for Deductible and Co-Payments at the time of service and any balances due after insurance has made payment. *Indicates Required Field **Date:_____**

*Patient Name:_____*DOB:_____*SS#:_____

If under 18, Responsible Party Name:_____

*Address:_____
(House Number and Street) (City) (State) (Zip Code)

*Primary Phone:_____ ☐ Cell ☐ Home

Secondary Phone:_____ ☐ Cell ☐ Home

Appointment Reminders:

Primary	**OR**	Secondary
☐ Call		☐ Call
☐ Text		☐ Text

*Email_____

*Is this a Worker's Comp Claim? ☐ Yes ☐ No *Car Accident? ☐ Yes ☐ No

*Have you been covered under Home Healthcare? ☐ Yes ☐ No If Yes, date discharged:_____

*Primary Insurance:_____Subscriber's Name:_____
DOB:_____SS#_____ Subscriber ID #:_____
Relationship to patient:_____

*Secondary Insurance_____Subscriber's Name:_____
DOB:_____SS#_____ Subscriber ID #:_____
Relationship to patient:_____

*How did you hear about us? (Check all that apply)

☐ TV Ad	☐ Community Event	☐ Dr. Referral	☐ Saw Location
☐ Online Ad	☐ Seminar	☐ Twitter	☐ Newsletter
☐ Facebook	☐ Radio Ad	☐ Blog	☐ Promo Product
☐ Sponsorship	☐ Past Patient	☐ Gym Member	☐ Newspaper Ad
☐ Family/Friend			

If Family/Friend, Who? _____

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Have you EVER been diagnosed as having any of the following?

( ) Cancer: If yes, describe:	( ) Diabetes, are you insulin dependent? Y or N. (For PT: If yes then, foot check. Y or N.)
( ) Allergies, please list:	( )Rheumatic Fever
( ) Asthma	( ) Hepatitis
( ) Emphysema/Bronchitis	( ) Tuberculosis
( ) Hearing/Vision Impairment	( ) AIDS/HIV
( ) Seizures	( ) Obesity
( ) Artificial joints, please list:	( ) Healing problems/open wounds, if yes then list:
( ) Dizziness	( ) Osteoarthritis
( ) High or low blood pressure	( ) Rheumatic arthritis
( ) Mental illness/Depression	( ) Osteoporosis
( ) Dementia	( ) Anemia
( ) Heart Attack	( ) Epilepsy
( ) Angina	( ) Systemic Lupus
( ) Vascular Disease	( ) Drug or Alcohol Dependency
( ) Multiple Sclerosis	( ) Thyroid Problems
( ) Acute Respiratory Infection	( ) Acute Pulmonary Heart Disease
( ) Stroke	( ) Pneumonia

List Medication(s) or provide a list with dosages:

_____

_____

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