

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
Northern Physical Therapy, PLLC

Date

Health. Wellness. Results.

Patient Information



www.nptny.com

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 <input type="checkbox"/> Call	OR Secondary <input type="checkbox"/> Call
<input type="checkbox"/> Text	<input type="checkbox"/> 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: _____

To whom do you authorize us to disclose your personal health information?

Name: _____ Phone: _____ Relationship to Patient: _____

*Have you ever previously been a patient of NPT? Yes No

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

- | | | | |
|------------------------------------|---|--|---------------------------------------|
| <input type="checkbox"/> TV Ad | <input type="checkbox"/> Dr. Referral | <input type="checkbox"/> Family/Friend: (Who?) _____ | |
| <input type="checkbox"/> Online Ad | <input type="checkbox"/> Seminar | <input type="checkbox"/> Sponsorship | <input type="checkbox"/> Event |
| <input type="checkbox"/> Facebook | <input type="checkbox"/> I'm a Gym Member | <input type="checkbox"/> Radio Ad | <input type="checkbox"/> Saw Location |

Patient Signature: _____

Health. Wellness. Results.

Patient Information



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

<input type="checkbox"/> Type 1 Diabetes	<input type="checkbox"/> Allergies, please list:
<input type="checkbox"/> Type 2 Diabetes	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Asthma	<input type="checkbox"/> Infectious Disease (Hepatitis, Tuberculosis)
<input type="checkbox"/> Emphysema/Bronchitis	<input type="checkbox"/> Kidney Problems
<input type="checkbox"/> Hearing/Vision Impairment	<input type="checkbox"/> AIDS/HIV
<input type="checkbox"/> Seizures/Epilepsy	<input type="checkbox"/> Obesity
<input type="checkbox"/> Artificial joints, please list:	<input type="checkbox"/> Healing problems/open wounds, if yes then list:
<input type="checkbox"/> Dizziness or Vertigo	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> High or low blood pressure <input type="checkbox"/> Medicated?	<input type="checkbox"/> Rheumatic arthritis
<input type="checkbox"/> Mental illness/Depression	<input type="checkbox"/> Osteoporosis or Osteopenia
<input type="checkbox"/> Dementia	<input type="checkbox"/> Anemia
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Developmental or Growth Problems
<input type="checkbox"/> Angina or Arrhythmia	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/> Pacemaker or Stent	<input type="checkbox"/> Other Autoimmune Disease
<input type="checkbox"/> Vascular Disease	<input type="checkbox"/> Drug or Alcohol Dependency
<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Thyroid Problems (High or Low)
<input type="checkbox"/> Acute Respiratory Infection	<input type="checkbox"/> Acute Pulmonary Heart Disease
<input type="checkbox"/> Stroke	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Cancer If Yes, Date: _____	<input type="checkbox"/> Other
<i>Describe:</i>	
List Medication(s) or provide list with dosages:	List Medical/Surgical History:

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Patient Information

Patient Health Questionnaire - PHQ

Describe your symptoms: _____

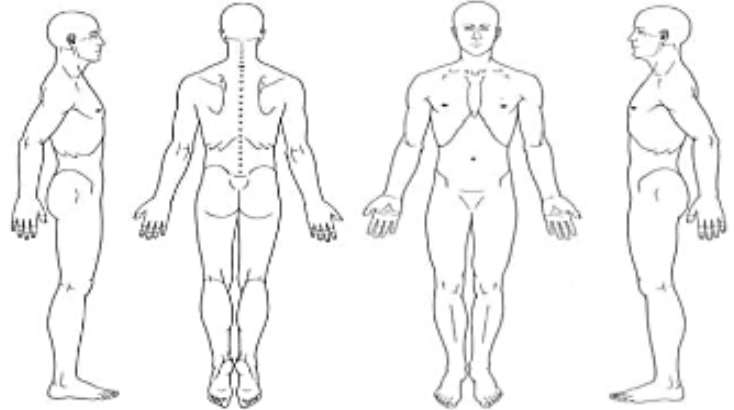
When did they start? _____

How did they begin? _____

How often do you experience your symptoms?

- ① Constantly (76% - 100% of the day)
- ② Frequently (51% - 75% of the day)
- ③ Occasionally (26% - 50% of the day)
- ④ Intermittently (0% - 25% of the day)

Indicate where you have pain or other symptoms:



What describes the nature of your symptoms?

- ① Sharp
- ② Dull Ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- ⑥ Tingling

How are your symptoms changing?

- ① Getting Better
- ② Not Changing
- ③ Getting Worse

During the past 4 weeks:

Indicate the average intensity of your symptoms:

- None Unbearable
- ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

How much has pain interfered with daily tasks?

- ① Not at all
- ② A little Bit
- ③ Moderately
- ④ Quite a bit
- ⑤ Extremely

How much of the time has your condition interfered with social activities?

- ① Rarely
- ② Occasionally
- ③ Regularly
- ④ Frequently
- ⑤ Always

How would you rate your overall, general health? ① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

Who have you seen for your symptoms? _____

What treatments have you received, and when? _____

What tests have you received, and when? (Xrays, CT Scan, MRI, etc.) _____

Have you had similar symptoms in the past? Yes No

If so, who did you see for treatment? _____

If you are not retired, a homemaker, or a student, what is your current work status?

- Full-time
- Part-time
- Self-Employed
- Unemployed
- Other

What is your occupation? _____

Patient Signature: _____ Date: _____

Diagnostic Testing Screening Tool

Patient Name: _____ Date: _____

If you currently feel or have felt any of the following symptoms within the past month, or if you have been diagnosed with any of the following conditions, please check the appropriate boxes.

This is a screening tool that can help your Therapist determine what diagnostics tests* may be appropriate for you.

Please check all that apply:

Section 1:			
<input type="checkbox"/>	Low Back and Radiating Pain	<input type="checkbox"/>	Neck Pain and Radiating Pain
<input type="checkbox"/>	Numbness, Tingling, or Burning Sensation in the Legs or Feet	<input type="checkbox"/>	Numbness, Tingling or Burning Sensation in the Arms or Hands
<input type="checkbox"/>	Weakness in the Legs or Arms	<input type="checkbox"/>	Loss of sensation in Hands/Feet
<input type="checkbox"/>	You have Diabetes or Neuropathy	<input type="checkbox"/>	Daily alcohol 3 glasses or more
<input type="checkbox"/>	Thyroid Dysfunction	<input type="checkbox"/>	Muscle Disease/Muscle Cramping
Section 2:			
<input type="checkbox"/>	Tendinitis/Bursitis/Arthritis	<input type="checkbox"/>	Shoulder Pain or Instability
<input type="checkbox"/>	Elbow Pain or Instability	<input type="checkbox"/>	Wrist-Hand Pain or Instability
<input type="checkbox"/>	Hip or Knee Pain or Instability	<input type="checkbox"/>	Ankle-Foot Pain or Instability
Section 3:			
<input type="checkbox"/>	Blurred Vision	<input type="checkbox"/>	Hearing Problems
<input type="checkbox"/>	Dizziness or Vertigo	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	Unsteady Gait	<input type="checkbox"/>	History of falls due to dizziness
<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	Hypotension
<input type="checkbox"/>	Anything else you consider important:	<input type="checkbox"/>	

Patient Signature: _____

*Electromyography/Nerve Conduction Studies, Autonomic System Testing, Somatosensory Evoked Potentials, Auditory & Visual Evoked Potentials, Musculoskeletal Ultrasound, Vestibular Testing.