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
315-393-2024
Fax: 393-2025

26908 Independence Way, Evans Mills
315-629-6255
Fax: 629-6254

307 Riverside Drive, Clayton
315-686-1757
Fax: 686-1758

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*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:_____

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

Name:_____ Phone:_____ Relationship to Patient:_____

Do you have any known allergies to latex, lanolin, or beeswax? ☐ Yes ☐ No (Please inform staff of additional allergies.)

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

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

☐ TV Ad ☐ Dr. Referral ☐ Family/Friend: *(Who?)*_____
☐ Online Ad ☐ Seminar ☐ Postcard ☐ Event
☐ Facebook ☐ I'm a Gym Member ☐ Radio Ad ☐ Saw Location

Patient Signature: _____ Date:_____

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

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

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Patient Health Questionnaire - PHQ

Describe your symptoms: _____

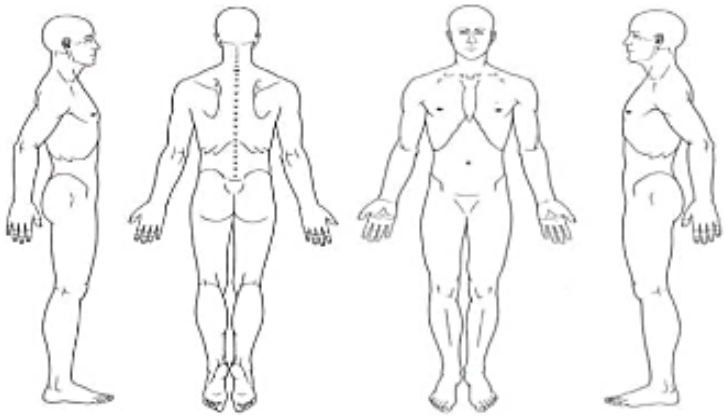
When did they start? _____

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 ④ Shooting
② Dull Ache ⑤ Burning
③ Numb 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* ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ *Unbearable*

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: _____

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

Patient Signature: _____

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

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