

Your good health is our goal!



www.nptnv.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

203 State Street
Ogdensburg, New York 13669

Phone: (315)393-2024
Fax: (315)393-2025

26908 Independence Way
Suite 102
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

Electromyography Laboratory Authorization & Consent for Testing

Electromyography(EMG) and Nerve Conduction Testing (NCS) are patient services provided in response to a wide variety of medical conditions for patients of all ages, regardless of gender, color, race, creed, national origin or disability.

The purpose of EMG/NCS testing is to evaluate the neuromuscular system and to find diseases that damage the nerves, muscles or the junctions between the nerves and muscles (neuromuscular junction).

All procedures will be thoroughly explained to you. During the NCS, mild electric currents will be applied to the skin on parts of your body. This is done to assess how quickly impulses travel in nerves and the NCS testing may be repeated on several different nerves. The EMG assesses muscle function. A fine needle electrode will be placed under your skin into the muscle being tested. The needle measures the electrical activity in your muscles and it may be repeated on several muscles. You also will be asked to contract your muscle during the EMG.

There are certain inherent risks with EMG/NCS. During the EMG, you may experience some discomfort similar to an injection and may have some residual soreness and bruising for a few days. EMG may also cause false results on muscle enzyme laboratory test and muscle biopsies. There may also be other risks depending on your medical condition: please discuss those with your referring physician or with your electromyographer. During NCS testing, you may feel a shock like sensation as the nerve is stimulated even though the amount of voltage applied is very small. You may feel your muscles twitch. As with EMG testing, there may be other risk depending on your medical condition; please discuss those with your referring physician or with your electromyographer.

Based on the above information, I agree to cooperate fully and to participate in the procedure. I acknowledge that I have read this authorization and agree to be compliant. I acknowledge that I have had the procedures explained to me.

Patient Signature

Date

Witness Signature

Date

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The patient is responsible to obtain prior authorization for Physical Therapy from Insurance. The patient is responsible for Deductibles and Co-payments at the time of service and any balances due after insurance has made payment.

Patient Information

Patient Name: _____ DOB: _____ SS #: _____

Ins. Subscriber's Name: _____ DOB: _____ SS#: _____

Mailing Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Height: _____ Weight: _____

Email: _____

Is this a Workers Compensation Claim?: _____ Car Accident?: _____

For Active Duty Military Personnel Only:

Commander's Name and Rank: _____ Phone# _____

Unit _____

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Present Status:

Please describe your symptoms (i.e. pain, numbness, burning, tingling, coldness, weakness, etc.)

When did your symptoms begin? _____

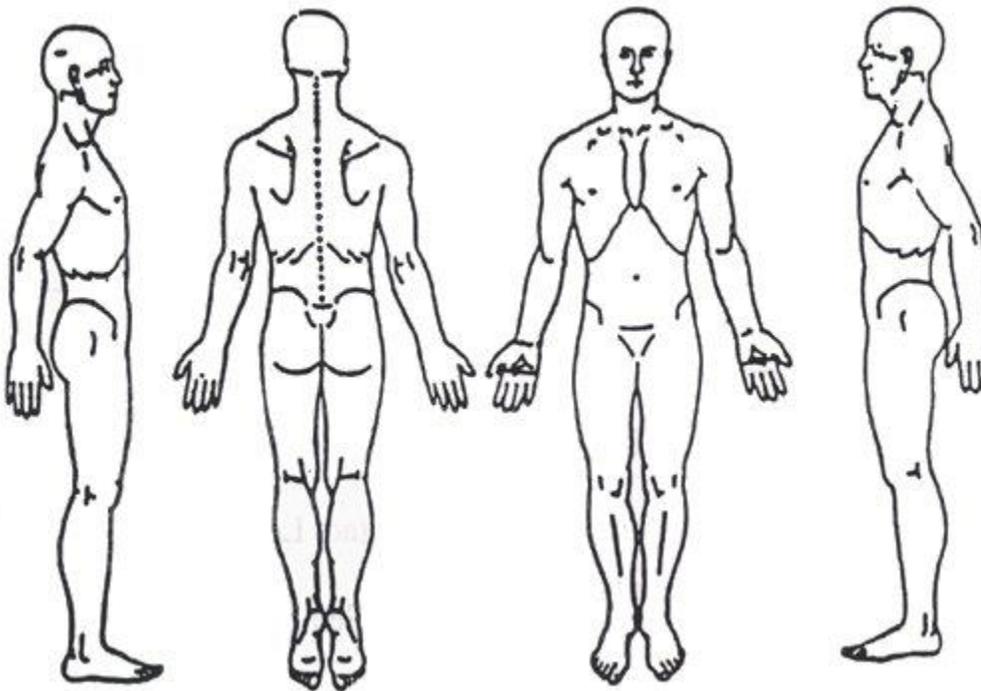
How frequently do you have your symptoms?

- Rarely (less than 10% of the day) Occasionally (11-25%) Intermittently (26-50%)
 Frequently (51-75%) Constantly (76-100%)

Do you have a history of falls? Yes No Do you drop things often? Yes No

Do your symptoms get better or worse at night? _____

Please mark on the following diagrams where you have your symptoms:



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Medical History:

Do you have a history of the following medical conditions? (Check all that apply.)

- Heart Condition Coronary Artery Disease Peripheral Artery Disease Diabetes
- Pacemaker High Blood Pressure High Cholesterol Thyroid Disorder Stroke / CVA
- Cancer Chemotherapy Radiation Therapy Connective Tissue Disease
- Asthma Neck pain Lower back pain Disc Herniations Arthritis
- Stenosis Neuropathy Alcoholism Drug Use HIV / AIDS Hepatitis
- Other _____

Do you experience any of the following symptoms?: (Check all that apply.)

- fever, chills, weight gain, weight loss, fatigue, lack of appetite, headache,
- dizziness, fainting, shortness of breath, chronic cough, chest pain, palpitations,
- heartburn, abdominal pain or bleeding, joint pains or arthritis, balance or
- coordination problems, bladder or bowel incontinence, bleeding disorders or anemia,
- depression or anxiety.

Are you a smoker? Yes No

Please list all medications you are taking: _____

Surgical History:

Do you have a history of the following surgeries? (Check all that apply.)

- Back Surgery Neck Surgery Joint Replacement Amputation
- CABG / Heart Surgery Angioplasty Removal of Mass / Cancer Other _____

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Please review the HIPAA notice provided to you by front desk regarding your diagnostic test.

I (print name) acknowledge that my signature below indicates that I have received and have had the opportunity to review the HODS Diagnostic HIPAA notice and ask questions about the policies and procedures contained within.

Signature

Date