Health. Wellness. Results.
Patient Information

Northern Physical Therapy Payment Policy & Billing Procedures

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 (located at Front Desk). Our commitment to your well-being and gain of your physical abilities is something everyone at Northern Physical Therapy takes very seriously and we want you to understand your role in this process:

I understand that payment for all physical therapy services is my responsibility regardless of insurance or other third-party coverage.

I understand co-payment, deductible and co-insurance amounts are to be paid at the time of service. I agree to pay Northern Physical Therapy, PLLC for any unpaid portion of my bill upon request. In the event a check is dishonored, I am responsible to pay Northern Physical Therapy a $35 returned check fee. I agree to give NPT a credit card to keep on file and to have NPT charge my weekly copays and/or no show/cancelation fees unless I make a payment at the time of service using an alternate method.

I authorize Northern Physical Therapy, PLLC to release to appropriate agencies any information acquired in the course of my examination and treatment necessary to secure payment for services provided. I also understand that it is my responsibility to understand my health insurance policy and coverage and if special authorization from the insurance company is required prior to initiating physical therapy treatment.

Worker's Compensation and No-Fault benefits will be verified however, this does not guarantee payment. In the event of denial, the account will become my responsibility. I can request that Northern Physical Therapy bill my primary insurance and I will be responsible for any unpaid portions of my bill.

If there is a balance on your account, Northern Physical Therapy will send you a statement. All balances are expected to be paid in full upon receipt of the statement. Payments not received within 30 days are considered past due and will be subject to late fees and/or interest penalties.

Failure to maintain a current patient account may result in placement of your account with an outside collection agency. I, or my representative, understand and agree that in the event it should become necessary to place my account with an outside collection agency, I will be responsible for collections fees of up to 30% of the principal balance owed. In the event that legal action becomes necessary to collect the balance due, I understand that I will also be responsible for attorney fees, interest, and court costs incurred.

Cancel/No Show Policy

_____**(initials)** This is to advise you of our cancel/no show policy. If you cancel or no show for a scheduled appointment without 24 hours' notice, you will be subject to a $25 fee. Please understand missing a scheduled visit limits others from receiving services for that day.

___________________________________ ________________

Signature of Patient or Guardian Date

Health. Wellness. Results.
Patient Information

*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
*Please indicate **any** ways that you have heard of NPT:
☐TV Ad ☐ Dr. Referral ☐Family/Friend: *(Who?)*____________________________
☐Online Ad ☐Seminar ☐Sponsorship ☐Event
☐Facebook ☐I'm a Gym Member ☐ Radio ☐Ad ☐Saw Location

Patient Signature: ____ Date: ___________________

Health. Wellness. Results.
Patient Information

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:*	( ) COVID-19 If yes, Date: ____________ ( ) Other
List Medication(s) or provide list with dosages:	List Medical/Surgical History:
Tobacco User: Yes ___ No ___	Body Mass Index: **FOR PT:** Blood pressure Weight: _____ Systolic: __________ Height: _____ Diastolic:__________

Health. Wellness. Results.
Patient Information

Northern
PHYSICAL THERAPY
& Fitness
www.nptny.com

Patient Health Questionnaire - PHQ

Describe your symptoms: ____

When did they start? ____

How did they begin? ____

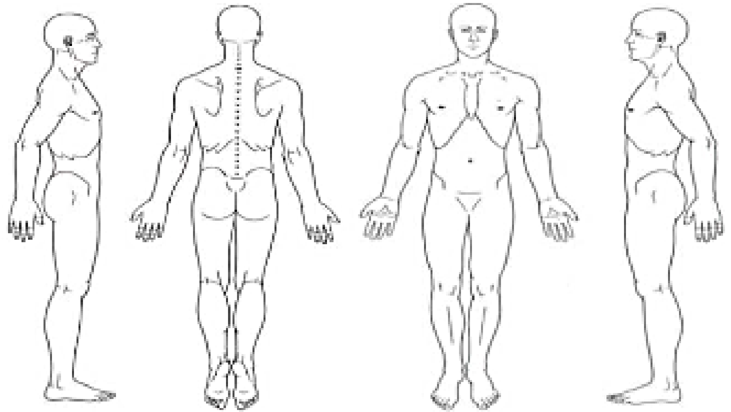
How often do you experience your symptoms?

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)

What describes the nature of your symptoms?

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

Indicate where you have pain or other symptoms:



How are your symptoms changing?

① Getting Better ② Not Changing ③ Getting Worse

During the past 4 weeks: *None* *Unbearable*

Indicate the average intensity of your symptoms: 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? (X-rays, 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:____________

Health. Wellness. Results.
Patient Information

www.nptny.com

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.