Port Jefferson Physical Therapy
Where your recovery becomes reality

HUNTINGTON
120 New York Ave #5W
Huntington, NY 11743
(631) 923-0578

PORT JEFFERSON STATION
300 Hallock Avenue
Port Jefferson Station, NY 11776
(631) 331-1070

PATIENT INFORMATION		**EMAIL ADDRESS:**	
First Name:	Last Name:	Middle Initial:	Date: / /
Address:	City:	State:	Zip:
Birth date: / /	Age:	☐ Male ☐ Female	S.S. #: - -
Home Phone: ( ) -	Alternative Phone (Cell, Pager): ( ) -	Spouse:	
Chose Clinic Because/ Referred to Clinic By ☐ Dr.:		☐ Insurance Plan ☐ Family ☐ Friend	
☐ Former Patient ☐ Close to Work/Home ☐ Website ☐ Yellow Pages ☐ Street Sign ☐ Other:			

WORK INFORMATION		
Employer:	Work Phone ( ) -	Ext.
Occupation:	Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed	

CARE PROVIDER INFORMATION	
Referring Dr:	Referring Dr. Phone: ( ) -
Regular Dr./PCP	Regular Dr./PCP Phone: ( ) -

INSURANCE INFORMATION	**(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)**
Primary Insurance Name:	
Subscriber's Name (If different):	Birth date : / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:	
Name of Secondary Insurance:	
Subscriber's Name:	Birth date : / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:	

AUTO OR WORK INJURY CLAIM	**(PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)**		
Insurance Name: ☐ Auto :	☐ Labor & Industries:		
Adjuster/Claim Manager:	Phone:	Ext.:	
Address:	City	State:	Zip:
Claim #:	Accident Date: / /	Cause:	

ATTORNEY INFORMATION			
Name:	Law Firm:	Phone: ( ) -	
Address	City	State:	Zip:

IN CASE OF EMERGENCY		
Name of Local Friend or Relative (Not Living at Same Address):		
Relationship to Patient:	Home Phone: ( ) -	Work Phone: ( ) -

I authorize my insurance benefits be paid directly to Port Jefferson Physical Therapy. I understand that I am financially responsible for any balance. I also authorize Port Jefferson Physical Therapy to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE DATE

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PAST MEDICAL HISTORY FORM

Patient Name _____

BLOOD PRESSURE	YES	NO
Hypertension	☐	☐
Low Blood Pressure	☐	☐
Normal Blood Pressure	☐	☐

HEART DISEASE	YES	NO
Heart Attack	☐	☐
Atherosclerotic Disease	☐	☐
Myocardial Infarction	☐	☐
Rheumatic Heart Disease	☐	☐
Heart Murmur	☐	☐
Do you have a pacemaker	☐	☐

MUSCLE CONDITION	YES	NO
Carpal Tunnel R/L	☐	☐
Tennis Elbow R/L	☐	☐
Back/Neck Problems	☐	☐
Limited Limb Movement	☐	☐

LUNGS	YES	NO
Asthma	☐	☐
Emphysema	☐	☐
Shortness of Breath	☐	☐

JOINT CONDITIONS	YES	NO
Upper Extremity	☐	☐
Dislocation	☐	☐
Lower Extremity Dislocation	☐	☐

OTHER CONDITIONS	YES	NO
Muscular Dystrophy	☐	☐
Rheumatoid Arthritis	☐	☐
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Gout	☐	☐
Fibromyalgia	☐	☐
Diabetes	☐	☐
Hearing Loss	☐	☐
Poor Eyesight	☐	☐
Fainting	☐	☐
Polio	☐	☐

Other: _____
_____
_____
_____

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
☐ None	☐ Sitting	☐ Low	☐ Smoking	Packs a Day ____
☐ 1-2 x Week	☐ Standing	☐ Medium	☐ Alcohol	Drinks a Week ____
☐ 3-4 x Week	☐ Light Labor	☐ High	☐ Coffee/Soda	Cups a Week ____
☐ 5+ x Week	☐ Heavy Labor			

What types of exercise do you perform? : _____
What things cause stress in your life? :

Are you taking any seizure medication? ☐YES ☐NO If yes list name: _____

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?

☐YES ☐NO If yes list name: _____

List all medications you are currently taking: _____

List all surgeries in the past two years (Including dates): _____

Are you pregnant? ☐ YES ☐ NO What week?: _____

Have you had any injuries related to work? ☐ YES ☐ NO If yes list body part and date.: _____

Have you had any Auto Accidents ☐ YES ☐ NO If yes list body part and date.: _____

Have you had Physical Therapy or Massage Therapy before? ☐ YES ☐ NO Where:

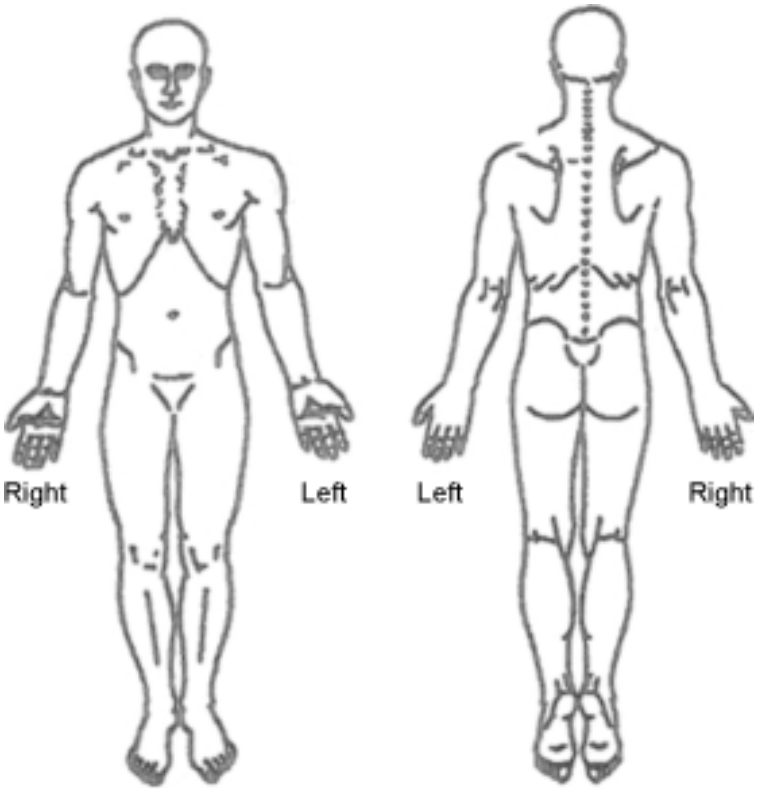
_____ _____
Signature of Patient, Parent, Guardian, Personal Representative Date

Pain and Symptom Status Report

Name _____ Date _____

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing.

Ache	Burning	Numbness
MMMM MM	– – – – –	OOOO OOO
Pins & Needles	**Stabbing**	**Other**
□□□□□□□□ □□□□□□	/ / / / / / / / / / / / /	x x x x x x x



Chief Complaint and Visual Analog Scale

My Chief Complaint is: _____

Date First Symptom of Your Problem Occurred on: _____

2nd Complaint: _____

3rd Complaint: _____

Please circle on the scale below to indicate your <u>CURRENT</u> level of pain:												
No Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Pain as bad as it gets**
Please circle on the scale below to indicate your <u>AVERAGE</u> level of pain:												
No Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Pain as bad as it gets**
Please circle on the scale below to indicate your <u>WORST</u> level of pain:												
No Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Pain as bad as it gets**

Additional Comments: _____

_____

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CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Your protected health information will be used by this practice, known as Port Jefferson Physical Therapy or disclosed to others for the purpose of treatment, obtaining payment or supporting the day-to-day health care operations of the practice.

We are providing you with a copy of our Notice of Privacy Practices. We request that you review the notice prior to signing this consent. You may request a restriction on the use or disclosure of your protected health information. If you wish to restrict your disclosure, you should make that request in writing.

This practice, however, may or may not agree to restrict the disclosure of your protected health information.

If we agree to your request, the restrictions will be binding. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of federal privacy standards.

You may revoke the consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date of your revocation of consent is received will not be affected.

This practice reserves the right to modify the privacy practices outlined in the notice.

SIGNATURE

I have reviewed this consent form and have reviewed the Notice of Privacy Practices. I give my permission to this practice to use and disclose my health information in accordance with it.

_____
Name of Patient (Print Clearly)

_____
Signature of Patient Date

_____
Signature of Patient Representative

_____
Relationship of Patient Representative to Patient

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COVID-19 HEALTH SCREENING FORM

Name_____ **Date**_____

Have you experienced new or worsening symptoms of any of the following conditions?

Fever (100 degrees or more)	Yes_____	No_____
Cough	Yes_____	No_____
Shortness of breath	Yes_____	No_____
Chills	Yes_____	No_____
Sore throat	Yes_____	No_____
New loss of smell or taste	Yes_____	No_____
Vomiting	Yes_____	No_____
Diarrhea	Yes_____	No_____

Have you been exposed to anyone who is known to have tested positive for COVID-19 in the last 14 days? Yes_____ No_____

In the past 14 days, have you traveled internationally or from a state with widespread community transmission of COVID-19 per the current NYS Travel Advisory? Yes_____ No_____

300 Hallock Avenue, Port Jefferson Station, NY 11776-1227
(P) 631.331.1070 (F) 631.331.1126
120 New York Avenue, Suite 5W, Huntington, NY 11743
(P) 631.923.0578 (F) 631.923.0580
portjeffpt.com

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Dear New Patient,

Our office participates in an appointment reminder system. Please indicate how you would like to receive this reminder. Please note, a response to this phone or email reminder is not required.

Text _____

Phone _____

Opt out _____

Thank you,

The Staff at Port Jefferson Physical Therapy

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Port Jefferson Physical Therapy, P.C.

Patient Compliance Form

Welcome to our clinic. We look forward to working with you to help you resolve your problems. In order to allow for a smooth process, the staff has a few expectations.

To maximize the effects of the treatment, we ask that you:

SHOW UP ON TIME. Our office makes every effort to begin your appointment on time so we ask that you arrive on time. We understand that being late is sometimes inevitable due to unforeseen circumstances (traffic, work, etc.). If you show up late, please be. advised that you may need to wait a little longer to be seen and that your treatment session may need to be adjusted. Showing up late may negatively .impact someone else's treatment as well.

AVOID CANCELLATIONS. We realize that sometimes cancellations are unavoidable. Please give as much notice as you can. Also, please note that if treatments are cancelled too often or there are too many no-shows, your therapist may reserve the right to discontinue your care. Do be aware that missing appointments can slow or prevent full benefits of your PT program. Some insurances have limited time frames and visit limits.

FOLLOW THE DIRECTIONS OF YOUR THERAPIST. As part of your care, your therapist may ·give you a number of exercises to do at home. Your therapist may also give you additional instructions that you need to follow through with. Not complying with all these instructions may negatively affect the outcome of your treatments and/or benefits.

Thank you so mnch for complying with the above guidelines.

I agree to comply with this policy:

Signature _____

Date _____

Rev. 11-18-13

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Guarantee Agreement

1. **Individual's responsibility for non-covered services:**

   In consideration of services rendered by Port Jefferson Physical Therapy to the undersigned patient, the undersigned promises to pay to Port Jefferson Physical Therapy any co-payment, co-insurance, or other charges required to be paid by-my health insurance coverage. In addition, I promise to pay for all services that are not covered by my health insurance plan provided I am informed of.same prior to the rendering of said service.

2. **Assignment of benefits:**

   I hereby assign to Port Jefferson Physical Therapy all monies and/or benefits to which I am entitled from my insurance/HMO/third party payer, government agencies, or those who are financially liable for my medical care.

3. **Authorization to release records:**

   I hereby authorize Port Jefferson Physical Therapy to release to my iusurer/HIYIO/third party payer, governmental agencies, or to whoever is financially responsible for my medical care all information needed to substantiate payment for such medical care and, if required, for precertification/prior approval purposes.

Our office reserves the right to charge for an office visit, if the appointment is not cancelled 24 hours prior to the appointment.

Signature _____

Date _____