

Richmond Physical Therapy, PC

1785 Forest Avenue Staten Island, NY 10303
3377 Richmond Avenue Staten Island, NY 10312

PLEASE NOTE THERE ARE 5 PAGES TO FILL OUT AND SIGN.

Patient Personal Information

Name: _____
 Last Name First Name MI
Date of Birth: _____
 MM/DD/YY
SSN Number: _____
Sex: Male/Female
Marital Status: _____
Address: _____

City: _____
Zip Code: _____
Home Telephone: _____
Cell Phone Number: _____
Send appointment reminder text?: Y/ N
Best Number to reach you: Cell/Home
Email ID: _____

Emergency Contact

Phone: (H) _____ (C) _____
Relationship: _____

Who is your PCP/ Doctor? _____
Who referred you? _____

Work Information

Occupation: _____
Name of Employer: _____
Work Address: _____

Work Phone: _____

Insurance Information

Primary Insurance

Primary Insurance Holder: _____
Primary person's SSN: _____
Person's Birth date: _____
Relationship of Primary insurance holder to patient: _____
Insurance co: _____
ID no: _____

Secondary Insurance

Insurance Co: _____
ID number: _____

Worker's compensation/ No Fault:

Claim number: _____
Date of injury: _____
Who is the carrier insurance? _____
Lawyer's Name and Phone number: _____

Assignment and Release

I, the undersigned certify that I or my dependent have insurance coverage with _____ and assign directly to **Richmond Physical Therapy** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submission.

Responsible Party's Signature:

Date:

.....

.....

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Health History Form

Have you seen a PT before: Y/ N? If Yes, when _____ for which condition? _____

Name and Address of the doctors who have treated you for your condition:

Height: _____ **Weight:** _____

Please check symptoms you currently have:

- | | | |
|--------------------|-----------------------------|-------------------------|
| Balance Impairment | Burning eyes | Depression |
| Headaches | Lightheadedness | Loss of concentration |
| Loss of memory | Nausea | Ringing/buzzing in ears |
| Vertigo | Visual/ Sensory Disturbance | |

Please check Symptoms you currently have:

- | | | | | |
|---------------|---------------------|----------------------|---------------------|--------------------|
| AIDS/HIV | Cataracts | Herniated Disk | Parkinson's Disease | Tuberculosis |
| Anemia | Chemical Dependency | Herpes | Pinched Nerve | Tumors, Growths |
| Anorexia | Diabetes | High Blood Pressure | Pneumonia | Ulcers |
| Appendicitis | Emphysema | High Cholesterol | Polio | Varicose Veins |
| Arthritis | Epilepsy | Jaw Pain/TMU | Prosthesis | Whiplash |
| Asthma | Glaucoma | Kidney Disease | Psychiatric Care | Blood Clots |
| Goiter | Liver Disease | Rheumatoid Arthritis | Breast Lumps | Gout |
| Mononucleosis | Rheumatic Fever | Bronchitis | Heart Disease | Multiple Sclerosis |
| Scarlet Fever | Bulimia | Hepatitis | Osteoporosis | Stroke |
| Cancer | Hernia | Pacemaker | Thyroid Problems | |
| Other _____ | | | | |

EXERCISE	WORK ACTIVITY	LIFESTYLE
None _____	Sitting _____	Smocking Packs/Day _____
Daily _____	Light Labor _____	Coffee/Day _____
Moderate _____	Standing _____	Alcohol/Week _____
Heavy _____	Heavy Labor _____	High Stress Level Reason _____

Injuries/Surgeries you have had:	Description	Date
Accidents/Falls _____	_____	_____
Head Injuries _____	_____	_____
Broken Bones _____	_____	_____
Dislocations _____	_____	_____
Surgeries _____	_____	_____

MEDICATIONS

NAME and Dosage	Which condition are you taking it for?
_____	_____
_____	_____
_____	_____
_____	_____

**ALLERGIES
VITAMINS/SUPPLEMENTS**

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Name: _____

Date: _____

Visual Analogue Scale:

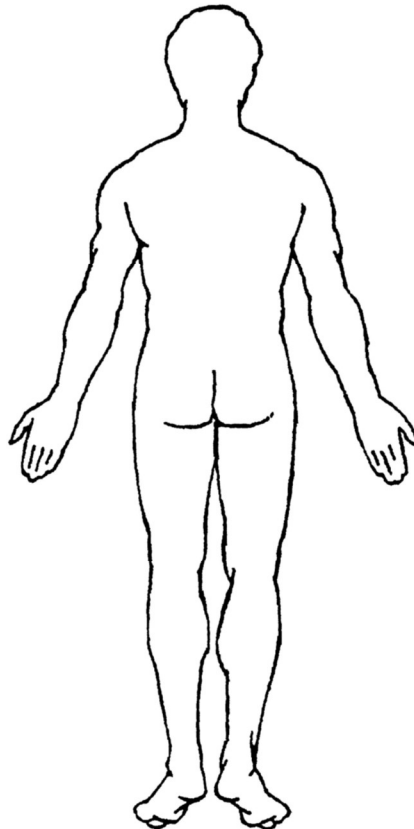
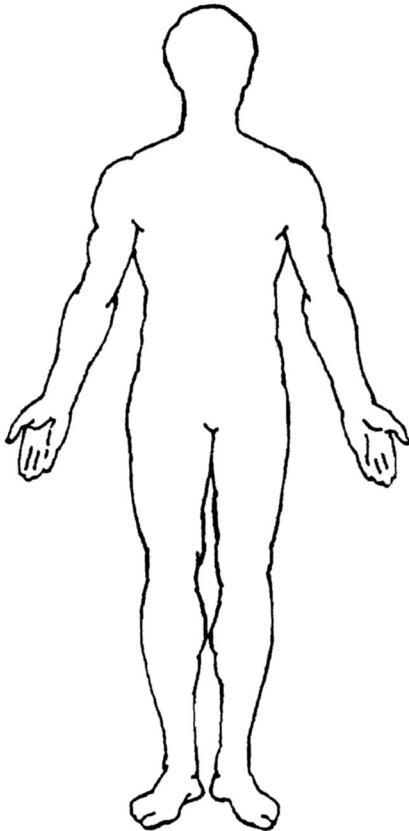
Please Rate your Pain on following Scale:

0: No Pain 5: Moderate Pain 10: Worst Pain



Pain Drawing:

Mark the area on your body with symbol **xx** where you the pain/ altered sensation.



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Consent for Purposes of Treatment, Payment & Healthcare Operations

I consent to use or disclosure of my protected health information by **Richmond Physical Therapy P.C.** for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Physical Therapist. I understand that analysis, diagnosis or treatment of me by **Richmond Physical Therapy P.C.** may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Richmond Physical Therapy P.C.** is not required to agree to the restrictions that I may request. However, if **Richmond Physical Therapy P.C.** agrees to a restriction that I request, the restriction is binding on **Richmond Physical Therapy P.C.**

I have the right to revoke this consent, in writing, at any time, except to the extent that **Richmond Physical Therapy P.C.** has taken action in reliance on this Consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Richmond Physical Therapy P.C. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Physical Therapist and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient and today’s date

Printed Name of Patient

Notice of Advice

(You must sign this if you start treatment without Referral/ MD Prescription for Physical Therapy)

The treatment may not be covered by your health care plan or insurer without a referral from a physician, dentist, podiatrist, or nurse practitioner and that the treatment may be a covered expense if rendered with a referral. We will be able to treat you up to 10 visits or 30 days whichever is earlier without a referral if it is covered by your insurance plan.

Physical Therapy Director:

Patient: I have read this notice – circle YES

Sign: 
Date:

Sign: _____
Date: _____

Dr Madhurani Mahajan, PT, DPT, CKTP

Name: _____

Richmond Physical Therapy, PC

Address: _____

1785 Forest Ave, SI, NY, 10303

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Informed Consent Form

I hereby request and consent to the performance of Physical Therapy treatments, Modalities including manual therapies on me (patient named below) by the NY state licensed Physical Therapist at Richmond Physical Therapy, PC.

I have an opportunity to discuss with Physical Therapist at Richmond Physical Therapy, PC or with other office or clinic personnel the nature and purpose of Physical Therapy treatments, exercises and other procedures used. I understand that the results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of Physical Therapy there are some risks to treatment, including disc injuries, increased muscle spasm, sprains. I do not expect the Physical Therapist to anticipate and explain all risks and complications, and I wish to rely upon the Physical Therapist to exercise judgment during the course of the procedure which the Physical Therapist feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intent this consent form to cover the entire course of treatment for my present condition and for any future condition(s) or which I seek treatment.

Patient Signature _____

Date _____

Witness Signature _____

Date _____

Attention

Richmond Physical Therapy Patients

NO SHOW AND CANCELLATION POLICY

Patients who do not keep their scheduled appointments or provide 24 hour notice of cancellation will be subject to a charge of \$30.00.

This is not a billable charge to any insurance company and is the sole responsibility of the patient.

X _____

Date _____