North Shore Physical Therapy

Patient Name: _____ Home Phone #: _____

Address _____ E-Mail: _____

City/State/Zip _____

Date Of Birth _____ **Occupation:** _____

Primary Care Physician: **Emergency Contact:**

_____ Contact Name _____

Home Phone: _____

Referring Physician: _____ Daytime Phone: _____

Chief Complaint: _____

Date symptoms started? _____/_____/_____

I live alone/with spouse/with children other: _____

Pacemaker? _____ **yes** _____**no**

Dominant Side? ___ R ___L **Affected Side?** ___R ___L **Are you pregnant?** ____Yes ____No

Please rate your pain in past 24 hours (circle one; 0 being no pain and 10 being the worst possible pain)

0 1 2 3 4 5 6 7 8 9 10

Have you had any fall in the past 12 months? _____ **yes** _____ **no**

Is your injury due to an auto accident or related to worker's compensation case? _____**yes** _____**no**

HAVE YOU HAD PHYSICAL THERAPY TREAMTENT IN THE PAST 365 DAYS? ____**yes** ____**no** **If yes, how many visits used?** _____

Have you seen any other healthcare provider for this condition? If yes, please specify: Date: _____/_____/_____

Doctor's Name and Location: _____

We require a copy of your health insurance card(s) for billing and ID verification purposes While we will do our best to assist you with verification of your insurance benefits, it is the patient's responsibility to know and comply with all insurance requirements.

All payment amounts provided to you by NSPT is an estimated amount based on the info obtained by our staff prior to your evaluation. For detailed information, please call your insurance carrier at your convenience. It is the patient's responsibility to inform us of any changes in your insurance plan/coverage prior to your initial visit and during the course of treatment.

We consider it appropriate to contact you on any phone number(s) that you make available to us. Please have our front desk staff remove any phone numbers from our files that you do not wish to be contacted on.

ConfidentialitDy Notice: information sent via email is not considered secured unless encrypted. We do NOT encrypt our emails; therefore, they are not 100% secure.

I, the above-named patient, have read the above and give my permission to North Shore Physical Therapy staff to communicate with me via email, when necessary or requested.

My email address is: _____@_____.com

Please check one:

( ) no restrictions

( ) with restrictions as follows: _____

Authorization For Treatment:

I, the undersigned, hereby authorize the medical staff of North Shore Physical Therapy Associates, Inc. to render such services as may be deemed necessary to me/my child/my dependent as listed above.

Authorization To Release/Obtain Information:

I, the undersigend, hereby authorize North Shore Physcial Therapy Associates, Inc. to release or obtain any information requested or required with respect to the above-referenced account to the extent necessary to manage care, process claims, or determine liability for payment and to obtain reimbursement.

Authorization To Use statistical outcome measures for research purposes:

I, the undersigned, hereby authorize North Shore Physical Therapy Associates, Inc. to use statistics gathered from my functional measurement forms to be anonymously used for statistical research purposes.

Assignment Of Benefits: I, the undersigned, hereby authorize and direct any payment of medical benefits to which I am entitled under Medicare, and/or private insurance, and/or other health plan(s), be made directly to North Shore Physical Therapy Associates, Inc.

Notice of Information Practices and Cancelation Policy:

I, the undersigned, hereby attest that I have seen North Shore Physical Therapy's Notice Of Information Practices and Cancellation Policy. I understand that a copy of the above said notices is available to me should I request one.

A Photocopy of this authorization/assignment is to be considered as valid as an original. This authorization/ assignment will remain in effect until revoked by me in writing to the assignee. By signing thereafter, I attest that I have read and understood the above-provided information.

I understand that I am financially responsible for any charges not covered by my insurance company(ies) payments.

Authorized Signature: _____ **Date:** _____/____/____

Case Therapist: Please initial after reviewing: _____