Patient Information

Patient Name: _____ **D.O.B** _____

Address _____**City** _____ **State** _____ **Zip** _____

Home Phone (_____**)** _____-_____ Work Phone (_____) _____-_____

Cell Phone (_____**)** _____-_____ **Circle One:** Male / Female

Emergency Contact _____ **Phone (**_____**)** _____-_____

Email Address _____

How did you hear about us? (i.e.: Doctor, Friend, Ad, Other**)** _____

Marital Status: Married_____ Single_____ Divorced_____ Widowed_____

We use automated reminders to confirm your appointments. Circle your preferred form of contact? phone / text / email

Occupation _____ Employer_____

Work Address _____ City _____ State _____ Zip _____

***Responsible Party Information** (if applicable)*

Relation to Patient: Self _____ Spouse _____ Parent _____ Other _____

Guarantor Name: _____ Date of Birth _____/_____/_____

Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____

Cell Phone (_____) _____-_____

Primary Insurance Information

Carrier's Name _____ **Phone (**_____**)** _____-_____

Policy/I.D. #: _____ **Group #** _____

Address _____ City _____ State _____ Zip _____

Authorization/Referral #:_____

Secondary Insurance Information

Carrier's Name _____ **Phone (**_____**)** _____-_____

Policy/I.D. #: _____ _____**Group #**_____

Health History Information

Patient Name _____ _____ _____

(Last) **(First)** **(M.I.)**

Injury_____ **Date of Onset**_____/_____/_____

Briefly describe previous treatment, if any: _____

_____

Do you have now, or have you ever had, any of the following?

Diabetes	Yes____ No____	Allergy or Cold	Yes____ No____
High Blood Pressure	Yes____ No____	Other Allergies	Yes____ No____
Pacemaker	Yes____ No____	Previous Surgery	Yes____ No____
Chronic Headaches	Yes____ No____	Seizures	Yes____ No____
Kidney Problems	Yes____ No____	Metal Implants	Yes____ No____
Nervous Disorders	Yes____ No____	Dizziness	Yes____ No____
Hernia	Yes____ No____	Cancer	Yes____ No____
Allergy to Heat	Yes____ No____	Pregnant	Yes____ No____
Bone Disease	Yes____ No____	Osteoporosis	Yes____ No____
Fractures	Yes____ No____	Bowel Problems	Yes____ No____
Bladder Problems	Yes____ No____	Recent Weight Loss	Yes____ No____
Pins & Needles	Yes____ No____	Circulatory Disease	Yes____ No____
Problems with Both Arms or Both Legs at the Same Time			Yes____ No____

If you answered YES to any of the above, please describe briefly and provide appropriate details:

_____

_____

Are you presently taking any medications? **Yes____ No____**

If you answered YES, please list your medications and for what condition: _____

_____

Have you had any x-rays, CAT scans, MRIs, or other diagnostic test for your current injury?

Yes____ No____

If you answered YES, please explain the findings as you understand them: _____

_____

Assignment of Benefits to NY SPORTS AND SPINAL PHYSICAL THERAPY, PLLC

Patient Name: _____

Insurance Policy #:_____

Insured Name: _____ Insured Date of Birth _____

Your relationship to the Insured: ❑ Parent ❑ Spouse ❑ Other:

_____

I hereby instruct and direct _____ insurance company to pay by check made out and mailed to:

NY SPORTS AND SPINAL PHYSICAL THERAPY, PLLC
838 SCARSDALE AVENUE
SCARSDALE, NY 10583

If my/this current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and **mail it to the above address** for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

This is a direct assignment of my rights and benefits under this policy.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

(Check each box and sign at the bottom)

- ❑ A photocopy of this Assignment shall be considered as effective and valid as the original.
- ❑ I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
- ❑ I authorize the use of this signature on all insurance submissions.
- ❑ I authorize NY Sports and Spinal Physical Therapy, PLLC to deposit checks made in my name.
- ❑ I authorize NY Sports and Spinal Physical Therapy, PLLC to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- ❑ I understand that I am financially responsible for all charges whether or not paid by insurance.

Dated this _____ day of _____, 20_____.

_____ _____

Signature of Policyholder Witness

_____

Signature of Claimant, if other than Policyholder

CANCELLATION/ NO SHOW POLICY

Please call our facility 24 hours prior to your scheduled appointment should you need to cancel. Cancellations or no shows without 24-hour notice within your treatment plan will result in a discharge from our facility as well as a cancellation fee of $75.00.

Signature: _____ *Date:* _____

PRIVACY PRACTICES

A copy of NYSSPT privacy practices is located at the front desk. You may also request a copy for yourself. This acknowledgement reflects the privacy standards set forth by the Department of the Health and Human Services.

Signature: _____ *Date:* _____

CONSENT FOR CARE and TREATMENT (pt.'s under 18 years of age)

I, the undersigned, do hereby agree and give my consent to NY SPORTS AND SPINAL PT to furnish the medical care and treatment considered necessary and proper in assessing and treating _____'s physical condition.

Parent/ Guardian: _____ *Date:* _____

OFFICE STAFF INITIALS: _____ **DATE: _____**

SCARSDALE
MAILING ADDRESS: 838 SCARSDALE AVE, SCARSDALE, NY 10583
P: 914-722-9200 F: 914-722-9201
WWW.NYSSPT.COM