Name: ____ Date of Birth: ____________

Nickname: ______________________ Phone: ____________________ Email: _______________________

Address: ________________________________City: _______________Zip Code: ____________

Emergency Contact: _________________________ Relationship: ________________ Phone: _____________

Referring Physician: ________________________ Primary Care Physician: __________________________

-Welcome to Churchville Physical Therapy, PC (CPT). Please read this document carefully and complete all the necessary information. If you have any questions or concerns please feel free to discuss them with our staff.

We at Churchville Physical Therapy, PC respect our patient's rights to privacy at all times. As required by the **Health Insurance Portability and Accountability Act (HIPAA)** we adhere to the standards set forth in the **Notice of Privacy Practice**. Copies are available at the front desk. This document states that we reserve the right to contact you by mail or phone. We may leave messages regarding appointment confirmation, scheduling, payment for services and treatment issues. By signing this agreement you are granting us permission to do so. I hereby acknowledge that I have received a copy of Churchville Physical Therapy, PC's Notice of Privacy Practices.

PATIENT or GUARDIAN SIGNATURE ____DATE_______________

INSURANCE INFORMATION:

Insurance Plan: ____________________________________ Member ID: ____________________________________

Subscriber Name: ______________________________________Subscriber Date of Birth: ______________________

Secondary Insurance Plan: _________________________________ Member ID: _______________________________

Subscriber Name: ______________________________________ Subscriber Date of Birth: _____________________

OPTIONAL: DESIGNATION OF PERSONAL REPRESENTATIVE

** For patients wishing to elect a personal representative who has legal authority to act on a patient's behalf in making decisions related to the patient's health care,* ***this includes scheduling and/or changing appointments.***

I, hereby designate (Names) ____,

(Relationship to patient)______________________________as my personal representative for purposes of all rights, obligations and responsibilities created under the HIPAA Privacy Rules.

I acknowledge and agree the Churchville Physical Therapy, PC, may disclose my protected health information to my personal representative and that my personal representative has the authority to authorize the practice to use and disclose my protected health information.

SIGNATURE ____DATE_________________

MEDICARE PATIENTS ONLY - BENEFICIARY NOTICE

* **Benefits** under Medicare allow for 80% coverage once your deductible has been met up to an annual threshold of $2040. Services deemed medically necessary, as assessed every 10 visits, are covered beyond the threshold.
* Medicare **will not** pay for outpatient physical therapy if you are **currently receiving home health care.** Any payment for services provided by CPT while receiving home health care will be your responsibility.
* **Medicare does not** cover Iontophoresis, Phonophoresis, or Electrical Stimulation. If this treatment is ordered by your doctor, payment will be your responsibility.

I have been informed of my Medicare benefits and fully understand all the above regarding my outpatient physical therapy coverage.

PATIENT/REPRESENTATIVE SIGNATURE______________________________DATE______________

OVER

WORKERS' COMPENSATION OR NO FAULT PATIENTS ONLY

Have you received any physical therapy care that was billed to worker's comp or no fault? Yes No (Check one)

Date of Injury: ________________Name of Carrier: ____

Carrier Address: ____ Carrier Phone: _________________________

Name of Adjuster: _____________________________ Claim Number: ________________________________

Employer: ___________________________________ Employer Address:____

WORKERS' COMP and NO-FAULT PATIENTS must provide third party insurance at the time of the evaluation. If the patient does not have personal insurance coverage then he patient will be responsible for all costs accrued if claim is denied. **PLEASE INITIAL**_________

PROCEDURE AND BILLING POLICY

* Please provide **24 hour notice** for appointment cancellations. Cancellations and no-shows are documented and may affect the validity of your insurance claim. Patients who fail to show up for their scheduled appointment may be charged a **$25.00 fee.** We understand that situations may arise that prevent you from keeping your appointment. A voicemail box is available 24/7 for you to leave us a message. **PLEASE INITIAL** ___________

* The patient is responsible for any payment not covered by their contracting/non-contracting insurance company. Any check received by the patient intended for services rendered at CPT must be remitted to CPT Physical Therapy. **PLEASE INITIAL** ___________

*** Co pays are due when services are rendered. PLEASE INITIAL** ___________

*Patients with Co insurance plans will receive a bill once the insurance has paid. Payment is due within 30 days of the printed statement.

*Monthly statements will be generated for all patient balances. Payment is due within 30 days of the printed statement. Patients will receive a maximum of 3 monthly statements and at this time will start to accrue billing fees.

*Failure to pay balances within the 90days will result in billing and/or collection fees. Patient will be responsible for a $25 billing fee per monthly statement that is generated by CPT after the 90 days. Any accounts sent to collections at this time will receive an additional $50 fee to cover collection costs.

*There is a $25.00 fee on all returned checks.

* New York State allows patients to receive physical therapy services for up to **30 days or 10 visits WITHOUT a present medical referral/prescription.** Any patient who chooses to receive physical therapy using this "Direct Access Law" at CPT must sign a direct access form prior to their evaluation. **I am choosing to receive physical therapy services using the Direct Access law: Yes No**

* It is the patient's responsibility to make sure a current doctor's referral is obtained prior to treatment. **Patients are responsible for knowing their own out-patient physical therapy benefits, co-pay and deductible amounts.** Please contact the customer service department of your insurance company for information. CPT will obtain any preauthorization required by your insurance company.

*Any patients currently receiving **home health care** must check with the insurance carrier to see if Physical Therapy treatment will be covered in addition to home health care. Any payment for services provided while receiving home health care will be the patients responsibility.

I assign Churchville Physical Therapy, PC all rights, privileges and remedies to payment for services rendered to which I am entitled. I have read and fully understand the above statements and acknowledge my responsibility to Churchville Physical Therapy, PC for all charges incurred.

PATIENT/GUARDIAN SIGNATURE ____**DATE**_________________________

GUARDIAN NAME (if applicable) ____

CHURCHVILLE PHYSICAL THERAPY, PC

Patient Information Sheet

7 Washington Street, Suite A100
Churchville, NY 14428
(585) 293-9160 Office (585) 293-9175 Fax

PAST MEDICAL HISTORY FORM

Name ____ Today's Date ________________________

Are you presently working? Yes No Date of next visit to physician ______________________

Date of injury/onset? __________________ Have you had these symptoms before? Yes No

Do you have or have you had any of the following:

	Yes	No		Yes	No
Asthma/ Breathing Difficulty	___	___	Liver/ Gallbladder Problems	___	___
Bowel/ Bladder Abnormality	___	___	Metal Implants	___	___
Cancer	___	___	Nausea/ Vomiting	___	___
Chest Pain/ Angina	___	___	Osteoarthritis	___	___
Diabetes	___	___	Osteoporosis	___	___
Dizziness	___	___	Pacemaker	___	___
Fractures	___	___	Rheumatic Arthritis	___	___
Headaches	___	___	Ringing in Ears	___	___
Heart Attack	___	___	Seizures	___	___
Heart Disease	___	___	Skin Abnormalities	___	___
Heart Palpations	___	___	Smoking	___	___
Hernia	___	___	Stroke	___	___
High Blood Pressure	___	___	Surgeries	___	___
Hypoglycemia	___	___	Urine Leakage	___	___
Kidney Problems	___	___	Other	___	___

If you answered YES to any of the items above, please briefly explain and give the date. Include any other pertinent information regarding your past medical history.

(PLEASE TURN OVER)

Do you have any allergies? Yes No

If Yes, please list ____

Are you presently taking any medication? Yes No

Medication: Used for:

Do you participate in any sports, exercise, or activities on a regular basis? Yes No

PLEASE INDICATE BELOW WHERE YOUR SYMPTOMS ARE LOCATED

KEY

Numbness	======
Pins and Needles	000000
Burning Pain	XXXXX
Stabbing Pain	////////

On a scale of 1 to 10 - Please rate your pain
(with 10 being the worst)

On Average __________

Right Now __________

Worst Ever __________