Patient Registration

D ate

Please Fill Out Entire Form Completely & Legibly

1.Patient Info

Last Name ____ First Name ____ Age ____ □ Male □ Female □ Other

Street Adress ____ City ____ State ____ Zip Code ____

Home Phone Number ____ Cell Phone Number ____ Email Address ____

SSN ____ Date of Birth *(mm/dd/yyyy)* ____ If Patient is a MINOR: Parent/Guardian Name & Signature HERE ____

Emergency Contact Person ____ Phone ____ Relationship ____

2. My Condition Info

My injury/ailment is related to…

□ AUTO/PERSONAL INJURY □ WORK INJURY

Insurance Adjustor Name ________________________

Phone ________________________

Work Company HR Name ________________________

Phone ________________________

□ OTHER: What you think may have caused it?

____

I have already had…

□ SURGERY: When and what type?

____

□ PHYSICAL THERAPY: When and where?

____

□ OTHER CARE:

____

____

____

____

3.Coordination of Benefits

□ Do you have a secondary insurance coverage that would pay whether or not your primary insurance would pay?

YES **NO**

If yes, please provide details:

ID or Policy Number________________________

Insurance Name________________________

□ Have you or your spouse served in the military? Are you using the insurance policy you obtained while in the active military service for this course of treatment?

YES **NO**

□ Are you a member of a union? Do you have insurance policy which is from your spouse's membership in the union?

YES **NO**

If yes, please provide details:

ID or Policy Number________________________

Insurance Name________________________

□ Have you made any changes to your Medicare policy this year?

YES **NO**

If yes, please provide details:________________________

□ For Medicare Patients: Are you receiving inpatient care?

YES **NO**

4. Referral Info - How Did You Hear About Us?

□ Found Fresh Pond on Social Media

□ Found Fresh Pond on Google/Yelp

□ Recommended by Insurance/Directory

□ Walked By Clinic

□ Recommended by Lawyer________________________

□ Recommended by Medical Professional ________________________

□ Recommended by Friend/Family ________________________

□ Other ________________________

I have read and agree to all the policies on the back of this form. **Patient Signature**________________________

Appointment Cancellation and No-Show Policy

At Fresh Pond Physical Therapy, we are committed to deliver quality, responsive and coordinated medical care. We greatly value our scheduled patients as they allow us to provide quality care in a timely manner.

When you schedule an appointment, we reserve that time just for you with our Physical Therapist. We are committed to honor the appointment time of our scheduled patients, so it is critical that you confirm your appointment within 24 hours of your appointment time and that you arrive on your scheduled time and no later than 10 minutes of the schedule.

We understand that unexpected matters come up and you may need to cancel an appointment. If that happens, we respectfully ask that you do the cancellation at least 24 hours in advance.

When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. Although we have always had an Appointment Cancellation Policy, circumstances have caused us to enforce a policy of charging for no-show appointments and those appointments not cancelled within 24 hours. There will be a fee of $30.00 assessed if we do not receive a call to cancel an appointment.

Our Responsibility to You:

- ✓ We guarantee to work with you to find the time that works best for you
- ✓ We will call you a day before your scheduled appointment

Your Responsibility to Us:

- ✓ If you need to reschedule, kindly contact us as soon as possible
- ✓ Arrive on time as we may not be able to hold your reserved time if you are more than 10 minutes late.

What will happen if you are late for your appointment?

- ✓ If you are 10 minutes late, we will try our best to see you as a walk-in patient with priority over other walk-in patients. However, if you are more than 30 minutes late, you will be seen as a walk-in patient and wait time will be based on our current availability.

Kindly contact us as soon as possible if you are running late.

Thank you for being a valued patient. We appreciate your understanding and cooperation. Following the plan of care prescribed by your Physical Therapist is the key to getting better faster.

SIGNATURE:________________________________ DATE:_____________

Assignment of My Benefits

IMPORTANT: All information must be **completed** or we will NOT be able to do the courtesy of dealing directly with your insurance.

1. Benefit Info

What is your deductible amount? $________ and Coinsurance %_________ (for the services you are seeking)

If you don't know this information, call the "800" number on your insurance card. The front desk person may be able assist you.

If you have a coinsurance or unmet deductible give your credit card info here. Nothing will be charged unless a balance is due.

- Credit Card Type: _______________ Exp. Date_____________ Card #:____

2. Policy Info

Patient Name:____ ID #_________________________ DOB_______

Insurance Policy #:__________________________________ Group # (if applicable)____

IS PATIENT INSURED THROUGH SOMEONE ELSE'S POLICY? Give their info here: (otherwise, skip this portion)

- Policyholder Name____ Date of Birth___________ SSN_________________
- Address (if different than Patient)____
- Relationship to Patient: __ Spouse __ Parent __ Other: ____
- Employer _______________________________________ Ph#___________________ Claim #___________________
- Employer Address ____

I hereby instruct and direct _____________________ insurance company to **pay by check made out to the "Healthcare Provider" to the right and mailed to** the address on the right (not mine). If my/this current policy prohibits direct payment to doctor/therapist, 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.

Healthcare Provider info:

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 the "Healthcare Provider" named above to deposit checks made in my name.
- ☐ I authorize the "Healthcare Provider" named above 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

FRESH POND PHYSICAL THERAPY

68-05 Fresh Pond Rd., Ridgewood, NY 11385 • 718.456.2545
43-01 Broadway, Astoria, NY 11103 • 718.274.4200
1007 Manhattan Ave., Brooklyn, NY 11222 • 718.383.7361

We help you reach your goal... *Most Insurance Accepted*

PATIENT'S RESPONSIBILITY

☐ **FINANCIAL OBLIGATIONS**

As a service and courtesy to our patients, Fresh Pond Physical Therapy, PC (FPPT) will submit charges for medical treatment to your insurance company. It is important to inform us of any changes in your insurance coverage as soon as they occur. Please present your current insurance card at your visit.

Should you incur medical costs and your insurance denied services, we will mail to you a bill/invoice/statement that contains the total cost of your service(s) and/or procedure(s) received during your office visit. This would be mailed promptly as soon as we receive the necessary documents from your insurance.

Should the balances remain unpaid and the claims are brought to collections agency for collection, you shall be responsible for an additional fee, including but not limited to, interest, service fees, or other incidental costs and expenses.

You acknowledge that you are ultimately financially liable for all charges whether or not paid by the insurance.

☐ **COPAYS ARE DUE UPON ARRIVAL**

Further, it is our payment policy to collect the appropriate payment due from the patient at the time the service is rendered. This may be your co-payment or "co-pay," deductible and/or co-insurance, and we do ask for payment at the time of your visit.

☐ **CELL PHONES MUST BE SHUT OFF OR SILENT**

We realize emergencies arise and therefore allow you to carry your cell phone during your session, however, please be courteous and set to silent mode or turn off. Thank you.

☐ **CHILDREN REQUIRING SUPERVISION ARE NOT ALLOWED TO ATTEND SESSIONS WITH YOU**

You may not bring children who require supervision with you to your appointment. If your child does not require supervision and is capable of waiting for you quietly then you may bring them. If any disturbance is caused to other patients or staff members, you may be asked to terminate your session early and attend to your child.

☐ **IMPORTANT NOTICE FROM THE FEDERAL GOVERENMNENT**

"It is unlawful to routinely avoid paying your copay, deductible, or coinsurance payments… even if your doctor allows it. Unless you complete a "Financial Hardship" form and qualify for financial assistance under Federal Standards, you may NOT routinely evade paying your responsibility portions for medical care as outlined in your insurance plan even if your doctor allows it. You both may be charged for breaking the law. This includes services deemed as "professional courtesy" and "TWIP's – Take what insurance pays." Failure to comply places you in violation of the following laws: Federal False Claims Act Federal Anti-Kickback Statute, Federal Insurance Fraud Laws, State Insurance Fraud Laws. Failure to comply may result in civil money penalties (CMP) in accordance with the new provision section 1128 A (a) (5) of the Health Insurance Portability and Accountability Act of 1996 [section 231 (h) of HIPAA]. Exceptional cases do apply. Please see contact info for more information. Office of Inspector General, Department of Health and Human Services. Contact by phone: 202 619-1343, by fax: 202 260-8512, by email: paffairs@oig.hhs.gov, by mail: Office of Inspector General, Office of Public Affairs, Department of Health and Human Services, Room 5541 Cohen Building, 333 Independence Avenue, S.W., Washington, D.C. 20201, Joel Schaer of Counse to the Inspector General, 202 619-0089".

We look forward to building a successful relationship with you that lasts a lifetime!

SIGNATURE:____________________ DATE:____________________

FRESH POND PHYSICAL THERAPY

68-27 Fresh Pond Rd., Ridgewood, NY 11385
78-01 Myrtle Ave., Glendale, NY 11385

INITIAL EVALUATION

(718) 456-2545
(718) 386-8300

We help you reach your goal...

Most Insurance Accepted

A complete medical history is necessary for a thorough evaluation. Please answer the following questions.

Your Name:				**Today's Date:**
Date of Birth:	**Age:**	**Height:**	**Weight:**	**Do You Smoke?** ☐ **Yes** ☐ **No**
Sex: ☐ **Male** ☐ **Female If female,** are you currently pregnant? ☐ **No** ☐ **Yes** **If yes,** ☐ 1st Trim ester ☐ 2nd Trimester ☐ 3rd Trimester				

Please check the following that you have been diagnosed with.

☐ Tuberculosis ☐ Cancer ☐ Arthritis

☐ Diabetes ☐ Hepatitis ☐ Stroke

☐ Heart Condition ☐ Epilepsy ☐ Respiratory Problems

☐ Other ______________________________

Who referred you for PT?

____

Primary Physician

____

Tell Us About Your Condition

When did you first notice the pain or have functional problems due to the condition/injury?
(Specific date) - ____/ ____/ ____
Recent flare-up? ☐ No ☐ Yes If yes, when ____/ ____/ ____
What activities are limited by this condition? (e.g. lift, reach)

____

Where and how did your injury/symptoms occur?

☐ Recreation ☐ Auto Accident
☐ Home ☐ Unknown
☐ Work ☐ Other ______________

Comments:

____

Work Information

Who is your employer? ______________ What is your job title/responsibilities? ______________

Are you currently working? ☐ No ☐ Yes If yes, numbers of hours per week _____ ☐ Full Duty ☐ Restricted Duty

How many total work days have you missed? _____ Do you have a case manager/QRC? ☐ No ☐ Yes

Your Therapist Will Complete this Section

Critical work, ADL, or leisure activities affected: ______________________________

- Lift/carry: ☐ ≤ 20 lbs. rarely to occasionally (**low demand**)
  ☐ > 20 lbs., or > 1lb. constantly or > 10 lb. frequently (**mod-high demand**)
  From ______________ to ______________.
- Repetitive motions related to condition:
  ☐ Occasional 1-33% (**low demand**)
  ☐ Frequent to Constant 34-100% (**mod-high demand**)
- Static positions related to condition (**mod-high**):
  ☐ Sit ☐ Stand ☐ Crouch ☐ Kneel ☐ Overhead work ☐ ______________
- Leisure Activities: ☐ None/minimally impact condition **(low demand)**
  ☐ Moderate-high intensity, competitive **(mod-high demand)**

Overall functional demand (work/ADL/leisure) ☐ **Low Demand** ☐ **Moderate-High Demand**

Comments:

PLEASE CONTINUE ON OTHER SIDE

0-10 pain scale (0 = No Pain; 10 = The Most Extreme Pain)

Worst pain rating: _____ **Best** pain rating: _____

For this injury, your medical care has included (check those that apply)

☐ Surgery: When? ___/___/___ What kind?________________________

☐ Injection: When? ___/___/___ Did it help? ☐ Yes ☐ No

☐ Other treatment: ________________________

☐ Physical therapy: When? ___/___/___to ___/___/__

What was done?________________________

☐ Chiropractor: When? ___/___/___to ___/___/___

What was done? ________________________

☐ Medications: ________________________

☐ X-ray ________________ ☐ MRI ________________

☐ CT scan ________________ ☐ Other: ________________

☐ Exercises: What kind? ________________________

Problems? ☐ No ☐ Yes ________________________

Are your symptoms:

☐ Constant? ☐ Intermittent?

☐ Getting Better? ☐ Getting worse?

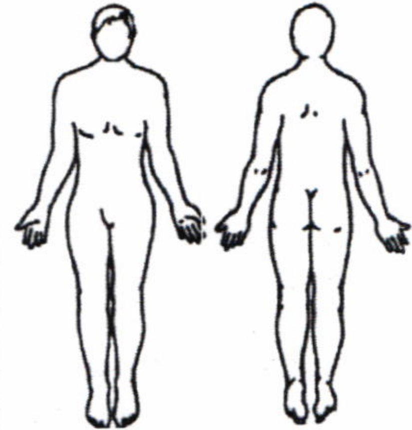
☐ Staying the same?

What makes your symptoms better?

____

Indicate on body diagrams **where** your symptoms are located

X = Pain **O** = Numbness



Functions

Please review the list below and indicate how the condition that brought you to therapy has affected your daily life. Circle the number that best applies to your current ability to function.

1 = No Problem	2 = Can Do With ***Some*** Difficulty	3 = Can Do With ***Great*** Difficulty
4 = Can't Do At All	N/A = Does Not Apply to This Condition	

Activity	**Rating**					**Therapist Comments**
Sitting (20 minutes)	1	2	3	4	NA	
Standing (20 minutes)	1	2	3	4	NA	
Squatting	1	2	3	4	NA	
Stairs	1	2	3	4	NA	
Walking	1	2	3	4	NA	
Sit to Stand	1	2	3	4	NA	
Driving	1	2	3	4	NA	
Sleeping	1	2	3	4	NA	
Bathing/Grooming	1	2	3	4	NA	
Dressing	1	2	3	4	NA	
Push/Pull	1	2	3	4	NA	
Lift/Carry	1	2	3	4	NA	
Bending	1	2	3	4	NA	
Light Work (Dust, Beds, Dishes)	1	2	3	4	NA	
Heavy Work (Lawn, Vacuum, Scrub)	1	2	3	4	NA	
Job Duties	1	2	3	4	NA	
Sports/Recreation	1	2	3	4	NA	
Other	1	2	3	4	NA	

Estimate your overall limitation to daily functions (0 to 100%) _____

What do you hope to accomplish in Therapy? ________________________

____

Patient was consulted regarding their goals? _____

Therapist Comments: ________________________

Appendix

WellRx Questionnaire

DOB_________________ Male___ Female _____

WellRx Questions

1. In the past 2 months, did you or others you live with eat smaller meals or skip meals because you didn't have money for food?
_____ Yes _____ No
2. Are you homeless or worried that you might be in the future?
_____ Yes _____ No
3. Do you have trouble paying for your utilities (gas, electricity, phone)?
_____ Yes _____ No
4. Do you have trouble finding or paying for a ride?
_____ Yes _____ No
5. Do you need daycare, or better daycare, for your kids?
_____ Yes _____ No
6. Are you unemployed or without regular income?
_____ Yes _____ No
7. Do you need help finding a better job?
_____ Yes _____ No
8. Do you need help getting more education?
_____ Yes _____ No
9. Are you concerned about someone in your home using drugs or alcohol?
_____ Yes _____ No
10. Do you feel unsafe in your daily life?
_____ Yes _____ No
11. Is anyone in your home threatening or abusing you?
_____ Yes _____ No

The WellRx Toolkit was developed by Janet Page-Reeves, PhD, and Molly Bleecker, MA, at the Office for Community Health at the University of New Mexico in Albuquerque. Copyright © 2014 University of New Mexico.

J Am Board Fam Med: first published as 10.3122/jabfm.2016.03.150272 on 11 May 2016. Downloaded from http://www.jabfm.org/ on 29 February 2024 by guest. Protected by copyright.