Saw Mill River Physical Therapy

Name: _____ Referring MD:_____ Date of Birth: _____

Diagnosis: Left/Right _____ Date of Onset: _____

Tx Diagnosis Chronic [ ]Insidious [ ] New Injury [ ]

Injury Surgery Performed: Yes [ ] No [ ] Date of Surgery: _____Type of Surgery:_____

Primary Concern/Chief Complaint: _____

Prior To This Injury/Surgery Were You Independent In The Following Areas? (Circle All That Apply)

Activities of Daily Living Self Care Work/Vocation Walking/Mobility Community Activities/Recreation/Sports

What Are Your Functional Difficulties/Limitations At This Time: (Circle All That Apply)

Sleep Self Care Activities of Daily Living Reaching/Pushing/Pulling Lifting/Carrying

Sitting/Standing Bending/Squatting Walking/Mobility Community Activities/Recreation/Sports

Pain Scale: In The Last Week, Please Rate Your Pain From O (None) To 10 (Extreme)

At Worst: _____Right Now: _____At Best: _____

Describe Your Pain: Burning Sharp Dull/ Achy Throbbing Shooting Numbness/Tingling

Aggravating Factors: (Circle Accordingly) Sitting Standing Walking Stairs ( Up / Down ) Bending
Reaching ( Overhead / Behind Back ) Bathing Sleeping

Pain Location: _____

Occupation: _____Currently Working: No Yes

Medical History: Do You Personally Have .....(Circle All That Apply)

History of Falls Osteoarthritis Cardiovascular Disease Seizure Disorders

Diabetes Mellitus Type I Diabetes Mellitus Type II Allergies Home Care

Other Pertinent Medical History: _____

Surgical History: _____

Previous Physical Therapy: _____

Have You Had Diagnostic Tests For This Injury/Pain? No [ ] Yes [ ] XRAY [ ] MRI [ ]

List All Of Your Current Medications/Dosages (All Prescription, Over The Counter, Herbals, Vitamins /Supplements)

Not Currently Taking Any Medications _____

What Are Your Goals For Physical Therapy? _____

Patient Signature: _____ Date: _____

Saw Mill River Physical Therapy

77 Kensico Drive
Mt. Kisco, NY 10549
Phone:(914) 752-1975
Fax: (914) 752-1977

**PATIENT INFORMATION**

Patient Name: _____ Date: _____
Last First

Address: _____
Street City State Zip

Home Phone: _____ Cell: _____ E-Mail _____

Female ( ) Male ( ) Age: _____ Date of Birth: _____

Referred by: _____

Employer: _____ Business Phone: _____

Address: _____ Occupation: _____

Emergency Contact: _____ Phone: _____
(Please Circle One: Spouse Parent Sibling Other)

Is Your Injury or Illness: Employment Related? Yes ( ) No ( ) Auto Accident Related? Yes ( ) No ( )

Did this injury occur at school or a school sponsored activity or sport? Yes ( ) No ( )

Have You Had Physical Therapy /Chiropractic Care Elsewhere This Year? Yes ( ) No ( )

If Yes, Where? _____
Name Of Facility And Address

Do You Play.....Golf ( ) Tennis ( ) Swim ( ) Dance ( ) Other (_____)

****Medicare Patients Only**
**Medicare Will Not Pay For Physical Therapy Services At The Same Time As Home Health Care**
Are You Now Receiving Home Health Services? Yes ( ) No ( )
Have You Had Home Health Within The Past 60 Days, But Were Discharged? Yes ( ) No ( )
If Recently Stopped, What Date Were You Formally Discharged From Home Health: _____

**Please advise us how you wish to be contacted:**

( ) E-mail ( ) Home Phone ( ) Work Phone ( ) Cell Phone

( ) Written communication. **Please note:** Bills will be mailed to the home address unless an alternative address is provided.

_____
Signature (Must Be 18 Years Or Older)

Saw Mill River Physical Therapy

## CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give consent for Saw Mill River Physical Therapy/Saw Mill Physical Therapy to furnish medical care and treatment to_____ (Print Name) considered necessary and proper in diagnosing or treating his/her physical condition.

Patient/Guardian:_____ Date: _____

## BENEFITS ASSIGNMENT /RELEASE OF INFORMATION

I, hereby assign medical benefits to which I am entitled, including Medicare, private insurance and third party payer to Saw Mill River Physical Therapy /Saw Mill Physical Therapy. A photocopy of this assignment is to be considered as valid as the original. I, hereby authorize said assignee to release all information including medical records, to secure payment.

Patient/Guardian:_____ Date:_____

## PHYSICAL THERAPY BENEFITS

We have contacted your insurance company in an attempt to verify your benefits. Benefits quoted are not a guarantee of payment. In the event that your insurance carrier mails payments directly to you for service performed by us, we request that you sign back of check and forward all payments along with the explanation of benefits (EOB's) to us. If your carrier determines that services are not medically necessary, it is your responsibility to inform the office right away. Failure to do so may result in a denial of your claims. If a denial is made, you will then be responsible for all non-covered services.

Patient/Guardian:_____ Date: _____

## RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I acknowledge that Saw Mill River Physical Therapy has provided me with a copy of their Notice of Privacy Practices regarding their policies and procedures concerning my Protected Health Information (PHI). I agree to release authorization to Saw Mill Physical Therapy to use my PHI when necessary for treatment, billing and the purposes mentioned in the notice.

Patient/Guardian:_____ Date: _____

Person responsible for payments of Physical Therapy Services

Patient/Guardian:_____ Date: _____

Print Name:_____

Saw Mill River Physical Therapy

# ASSIGNMENT OF BENEFITS/ERISA AUTHORIZED REPRESENTATIVE FORM

## Assignment of Insurance Benefits-Appointment as Legal Authorized Representative

I hereby assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to the Provider and the provider's representatives (hereinafter, "My Authorized Representatives") and I appoint them as my authorized representative with the power to:

File medical claims with the health plan
File appeals and grievances with the health plan
Discuss or divulge any of my personal health information or that of my dependents with any third party, including the health plan

I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

## Authorization to Release Information

I hereby authorize My Authorized Representatives to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

## ERISA Authorization

I hereby designate, authorize, and convey to My Authorized Representatives to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as My Authorized Representative in connection with any claim, right, or cause of action including litigation against my health plan (even to name me as a plaintiff in such action) that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as My Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such as benefits, claims, or reimbursement, and any other applicable remedy, including fines. I authorize communication with the Provider and his/her authorized representatives by email and my email address is _____@_____.Iunderstand I can revoke this authorization in writing at any time.
A photocopy of this Assignment/ Authorization shall be as effective and valid as the original.

Patient (Please Print): _____

_____ _____

Patient (Parent/Guardian If Patient Is A Minor) Date

Saw Mill River
Physical
Therapy

## ELECTRODE POLICY

During the course of your physical therapy, you therapist might suggest the use of electrical stimulation as an adjunct to your physical therapy treatment.

Due to increasing health-guard concerns, each patient having electrical stimulation as part of their therapy treatment is given the opportunity to purchase their own set of electrodes. Electrodes are special adhesive pads applied to the body that connect to the electrical stimulation machine. The cost is $10.00 for the small electrodes and the large electrodes. This is a one-time charge. The cost is not reimbursable by the insurance company.

Please note upon discharge of your treatment please request your electrodes. We are unable to store your electrodes after your discharge or discontinuing Physical Therapy care.

_____

Name

_____

Signature

Saw Mill River Physical Therapy

# ATTENDANCE POLICY

**(PLEASE BE ADVISED)**

**We require a 24 Hour Notice for Cancellation of Physical Therapy Appointments**

Saw Mill River Physical Therapy will make every effort to accommodate your particular schedule needs for your convenience. Specific time slots are reserved for each patient in order to minimize waiting times and insure you receive the highest quality care during your treatment.

Same-day cancellations, especially last-minute ones and no-shows, inhibit our therapists from meeting the needs of other patients as well as affecting the patients who have adhered to their scheduled time.

Cancellation of appointments under 24 hours will result in a **$50.00 charge** to the patient directly. If your call is after hours or the staff is unavailable to accept your call, please leave a message on the voicemail.

A no-show will result in a **$50.00 charge** to the patient directly.

Payment of these charges will be required at the time of your next appointment. They are not billable to your insurance company.

All cancellation and no-show appointments will be documented in our medical records and are subject to review by your physician and insurance/third party payer.

Please help us to serve all our patients to the best of our ability by keeping scheduled appointments. We encourage you to take a printout of your appointments or sign up for automatic e-mail notification. We appreciate your cooperation and adherence with this policy.

I have read and understood the above policy.

_____ _____

Signature Date

_____

Print Name