SAW MILL RIVER PHYSICAL THERAPY At Saw Mill Club

77 Kensico Drive
Mt. Kisco, NY 10549

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

Diagnosis: _____ ☐ Left ☐ Right Date of Onset: _____

_____

_____

Tx Diagnosis ☐ Chronic ☐ Insidious ☐ New Injury ☐ No New Aggravation/Injury

Injury/Surgery Performed: ☐ No ☐ Yes Date of Surgery: _____ Type of Surgery: _____

History of Present Condition/Mechanism of Injury: _____

Primary Concern/Chief Complaint: _____

Prior To This Injury/Surgery Were You Independent In The Following Areas? (Check 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: (Check 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 3 Days Please Rate Your Pain From a (Nolie) To 10 (Extreme)

☐ At Worst ☐ Right Now ☐ At Best

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

Aggravating Factors: (Check Accordingly) ☐ Sitting ☐ Standing ☐ Walking ☐ Stairs (☐ Up / ☐ Down)
☐ Bending Reaching (☐ Overhead I ☐ 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 ☐ X-Ray ☐ 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 (AT SAW MILL CLUB)
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: _____ Social Security #: _____

Referred by: _____ Reason/Diagnosis: _____

Employer: _____ Business Phone: _____

Address: ~~Emergency~~ _____ Occupation: _____

Contact: _____ Phone: _____

(Please Check One: ☐ **Spouse** ☐ **Parent** ☐ **Sibling** ☐ **Other)**

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

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

If Yes, Where? _____
Name Of Facility And Address

***Medicare Patient Only**
Medicare will not pay for Physical Therapy Services at the same time as Home Health Care
Are you 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? _____

Do You Play..... ☐ Golf ☐ **Tennis** ☐ Swim

INSURANCE INFORMATION

Primary Insurance _____ Policy Holder _____

Identification # _____ Group # _____ Specialist Co-Pay _____

Policy Holder Date of Birth _____ Relationship _____

Secondary Insurance _____ Policy Holder _____

Identification # _____ Group # _____ Specialist Co-Pay _____

_____
Signature (Must Be 18 Years Or Older)

SAW MILL RIVER PHYSICAL THERAPY

At The Saw Mill Club
77 Kensico Drive
Mt. Kisco, NY 10549
Phone: (914) 752-1975
Fax: (914) 752-1977

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 contracted your insurance company in an attempt to verify your benefits. The benefits below are estimated based on your individual policy. **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.

Primary Insurance _____

Your estimated portion will be: _____ due upon each visit

*PLEASE BE AWARE WE WILL IMPLEMENT A $10 LATE PROCESSING FEE FOR ALL PATIENT BALANCES NOT PAID AT THE TIME OF SERVICE AND EACH TIME A STATEMENT NEEDS TO BE SENT. IN ADDITION, ANY ACCOUNTS SENT TO COLLECTIONS WILL HAVE A 25% SURCHARGE FEE ADDED, ON THE PAST DUE BALANCE.

I have read the above information and I understand my responsibility for the payment of my account.

_____ _____

Patient/Guardian **Date**

SAW MILL/SAW MILL RIVER PHYSICAL THERAPY
At Saw Mill Club
77 Kensico Drive
Mt. Kisco, NY 10594
Phone: 914-752-1975
Fax: 914-752-1975

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 _____ @ _____ .

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

SAW MILL RIVER PHYSICAL THERAPY

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.

HIPPA privacy rules give the patient the right to request confidential communications or that a communication of the PHI be made by alternative means. Please advise us how you wish to be contacted. Check all that apply. If you do not check off your preferences, we will assume we can contact you by any of the following methods. Please note, e-mail is used for appointment reminders only and not a form of standard communication. **If you check off e-mail reminders. please provide at least 1 phone number.** Thank you.

☐ Can e-mail automatic appointment reminders to _____

☐ Home Phone _____

- ☐ Can leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Phone

- ☐ Can leave message with detailed information
- ☐ Leave message with call-back number only

☐ Cell Phone _____

- ☐ Can leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written communication. Please note: Bills will be mailed to the home address unless another address is provided.

- ☐ Can mail to my home address
- ☐ Can mail to my work address
- ☐ Can fax to this number: _____

Patient Name: _____ Date of Birth: _____

Signature: _____
(Parent signature if patient is a minor)

Date: _____

Saw Mill Physical Therapy

ELETRODE POLICY

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

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 you discharge or discontinue 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

Saw Mill River/ Saw Mill Physical Therapy

Use Of Club Facilities Waiver

Physical therapy services provided by Saw Mill River Physical Therapy and Saw Mill Physical Therapy encompass therapeutic exercises provided by the physical therapist within the confines of the physical therapy office, immediate hallway stairs, and swimming pool when the physical therapist is in direct supervision.

The use of Saw Mill Club exercise equipment, swimming pool classes, and amenities does not constitute physical therapy. Physical therapy patients at the Saw Mill Club may use the club's equipment, classes, Swimming pool, and amenities as an adjunct to their therapy immediately following their physical therapy session. The patient must acquire permission by the physical therapist for such participation. Use of the club equipment, classes, pool and amenities are at the sole responsibility of the patient. The patient recognizes that there are inherent dangers and risk of physical injury in using the club's facilities and participating in its activities. Children under the age of 14 are not permitted to use the club's fitness equipment.

Waiver:

I have read the above statement. I represent that I am in good physical condition and have no disability, impairment, or ailment preventing participation in the club's fitness and sports programs that I choose to partake in. The Club urges every member to have a medical check-up before participating in any of The Club's programs. I recognize the risk of injury in any exercise program and I am participating upon the express agreement and understanding that I am hereby waMng and releasing the above club from and against any claims, costs, and liabilities incurred while on these premises.

_____

Patient Name (Print)

_____

Patient Signature

_____

Date

SAW MILL RIVER PHYSICAL THERAPY
At Saw Mill Club
77 Kensico Drive
Mt. Kisco, NY 10549

CREDIT CARD PAYMENT AUTHORIZATION

If you would like us to, we can automatically process your copayments, insurance balances, or full payment on your credit card. We process bills on a weekly basis and you may receive a receipt upon request.

Please check one: ☐ MASTERCARD ☐ VISA ☐ DISCOVER

Account Number: _____ / _____ / _____ / _____

Expiration Date: _____ / _____ / _____ Security Code: _____

I hereby authorize Saw Mill River Physical Therapy to keep my signature on file and to charge my credit card for any patient balance on my account.

I understand that this authorization is valid for one year unless I cancel the authorization through written notice to Saw Mill River Physical Therapy.

Patient Name: _____

Card member Name: _____

Credit Card Billing Address (If business card, please indicate business address)

_____
Street

_____
City State Zip

Card Member Signature: _____ Date: _____