FARMINGDALE
Physical Therapy West
www.FarmingdalePhysicalTherapyWest.com

Phone: (516) 731-3583
Fax: (516) 731-3587

4277 HEMPSTEAD TURNPIKE, SUITE 209
BETHPAGE, NY 11714

Who can we thank for referring you?

We appreciate you choosing Farmingdale Physical Therapy West to be your provider of physical therapy services. If you would not mind, please indicate below how you found out about our clinic. Your cooperation with this survey assists FPTW to better anticipate present and future patient care needs.

Sean C. Serpe,
Practice Administrator

Patient Name: _____

Evaluation Date: _____

I was referred to Farmingdale Physical Therapy West by (please mark an "X" next to the statement below that best describes you):

_____ I am a **returning patient** who was treated previously by Butch Purslow and/or FPTW.

_____ My **medical care provider** referred me to FPTW: _____(Name)

_____ My **specialist provider** (e.g., orthopedic, neurological, sports medicine, no fault, workers compensation): _____(Name)

_____ I was referred by a **family member/friend**: _____(Name)

_____ I learned of FPTW from the **Yellow Pages**.

_____ I learned of FPTW from the **Internet**.

_____ I learned of FPTW from the **Shopping Cart**.

_____ Other: Please describe _____

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PRIORITY SURVEY

Patient Name: _____

Evaluation Date: _____

Please mark an "X" next to the statement or statements below that best describes you.

_____ MY INJURY/COMPLAINT IS RELATED TO AN **AUTOMOBILE ACCIDENT**.

_____ MY INJURY/COMPLAINT IS RELATED TO A **WORKPLACE INJURY** (OR AN INJURY WHICH OCCURRED DURING WORK).

_____ I HAVE A **WORKERS COMPENSATION** CLAIM OR CASE.

IF so, case number and carrier: _____.

_____ I HAVE A **NO FAULT** CLAIM OR CASE.

IF so, case number and carrier: _____.

_____ I HAVE A **PERSONAL INJURY CLAIM RELATED TO MY INJURY**.

_____ MY INJURY/COMPLAINT IS RELATED TO **SCHOOL SPORTS INJURY.**

IF so, case number and carrier: _____.

_____ I HAVE A **PACEMAKER.**

If so, name and telephone number of treating physician (or cardiologist):

_____.

_____ **I HAVE RECEIVED PHYSICAL THERAPY AT ANOTHER FACILITY IN THE PAST YEAR.**

IF yes, what facility and when: _____.

IF yes, was it for the same injury: _____.

____ **NONE OF THE ABOVE**

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DEMOGRAPHIC INFORMATION

PERSONAL

Name_____ Date of Birth_____

Address_____City_____Zip_____

Social Security #_____-_____-_____ Home Ph#_____Cell Ph#_____

Employer_____ Address _____ Ph#_____

Emergency Contact_____ Ph#_____

Relationship_____ E-Mail Address_____

PRIMARY CARE Doctor_____ REFERRING Doctor_____

INSURANCE

Primary_____ Name of Insured_____

Date of Birth_____ Relationship: self_____ spouse_____child_____ other_____

Social Security #_____ Employer_____ Ph#_____

Secondary_____ Name of Insured_____

Date of Birth_____ Relationship: self_____ spouse_____child_____ other_____

Social Security #_____ Employer_____ Ph#_____

Are you under chiropractic care for this case? YES / NO

Can patient be called at home? YES / NO

Can messages be left on voicemail? YES / NO

Can patient be called at work? YES / NO

Can messages be left on voicemail at work? YES / NO

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DEMOGRAPHIC INFORMATION (continued)

I hereby authorize payment of medical benefits to Henry G. Purslow, P.T., P.C., for services rendered by a licensed physical therapist or physical therapist assistant employed by Henry G. Purslow, P.T., P.C. I understand that I am financially responsible for any balance not covered by my insurance. I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request all authorized benefit payments be made on my behalf.

I hereby acknowledge that not all the providers employed by Henry G. Purslow, P.T., P.C. may be in network with my health insurance. I hereby authorize Henry G. Purslow, P.T., P.C. to bill my insurance as out of network if my treating therapist is not in network with my insurance plan. I will continue to pay my in network copay/coinsurance, as well as sign over any payment I may receive from the insurance company with the corresponding explanation of benefits.

I hereby acknowledge that Henry G. Purslow, P.T., P.C. will add a three (3)% charge on all past due balances, as well as the cost of any collections fees (equal to thirty (30)% of the balance).

In the event of a same day cancellation or no show of a scheduled appointment, Henry G. Purslow, P.T., P.C. reserves the right to charge a $10 cancellation/no show fee.

PLEASE NOTE: IF YOU DO NOT HAVE A PRESCRIPTION FROM YOUR PHYSICIAN, PODIATRIST, NURSE PRACTICIONER, OR DENTIST, OR IF YOU HAVE BEEN RECEIVING HOMECARE, YOUR PHYSICAL THERAPY VISITS MAY NOT BE COVERED BY INSURANCE.

Patient Signature_____ Date_____

Parent/Guardian Signature_____ Date_____
(If applicable)

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MEDICAL HISTORY

Name: _____ Date: _____

Please List:

Past Medical History: _____

_____

_____

_____

_____

Past Surgical History and Date(s): _____

_____

_____

Medical Testing (MRI, CT Scan, X-Ray)

Type: _____ Location/Provider: _____

Date: _____

Type: _____ Location/Provider: _____

Date: _____

Type: _____ Location/Provider: _____

Date: _____

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MY MEDICATION RECORD

List prescriptions, over-the-counter drugs, vitamins and herbal medicines.

Patient name: _____ Date: _____

Allergies: _____

Pharmacy name: _____ Phone: (____) _____

Primary doctor name: _____ Phone: (____) _____

Medication name/dose:	Medication treats (condition):	Medication frequency:	Notes/ questions:

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HIPAA NOTICE

I, _____, hereby authorize Henry G. Purslow, P.T., P.C., d/b/a/ Farmingdale Physical Therapy West, to use and/or disclose protected health information pursuant to the Notice of Privacy Practices that is posted in this office. I have also been given the opportunity to review and/or receive a copy of these privacy practices.

This authorization shall be in force and effect until such time that I give notification requesting the termination of this authorization.

I understand that I have the right to revoke this authorization in writing at any time by sending such written notification to the attention of Sean C. Serpe, Privacy Officer at 4277 Hempstead Turnpike, Suite 209A, Bethpage, New York 11714. I understand that a revocation is not effective to the extent that Farmingdale Physical Therapy West has relied on the use of disclosure of the protected health information.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to inspect or copy the protected health information to be used or disclosed as permitted under federal or state law to the extent the state law provides greater access rights, and/or refuse to sign this authorization.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

Person(s) we can discuss your care with other than your referring physician:

_____

THIS AUTHORIZATION IS BEING REQUESTED BASED ON THE NEW FEDERAL REGULATIONS THAT BECAME EFFECTIVE OCTOBER 2003 FOR ALL HEALTH CARE PROVIDERS.

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COMMUNICATION WAIVER

I, _____ hereby authorize Henry G. Purslow, PT PC d/b/a Farmingdale Physical Therapy West, and its employees, including Henry G. Purslow, Vincenzo Adduci, Erica Allocca, Scott Liptzin, Jillian Epifania and Stephaine Ringbauer to communicate via text messaging and e-mail with me regarding my treatment.

I hereby waive any of my rights under the Health Insurance Portability and Accounting Act of 1996, better known by its abbreviation, HIPAA in connection with any text messages and/or e-mails from Farmingdale Physical Therapy West and its employees. This waiver is not intended as a waiver of any of my other HIPPA rights (unless so stated in another document).

This waiver shall be in force and effect until such time that I give notification requesting the termination of this waiver.

I understand that I have the right to revoke this waiver in writing at any time by sending such written notification to the attention of Sean C. Serpe, Privacy Officer at 4277 Hempstead Turnpike, Suite 209A, Bethpage, New York 11714.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative

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Electric Stimulation Pad Policy

Electric Stimulation is a form of treatment that your referring physician and/or physical therapist may find necessary for progress in your treatment plan.

For sanitary reasons, all patients requiring electric stimulation will be responsible for a $10 fee for a personal set of pads.

Thank you for your cooperation.

Signature: _____ Date: _____

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PHYSICAL THERAPY INITIAL EVALUATION FORM

PATIENT INFORMATION

NAME_____ OCCUPATION _____

AGE_____ HEIGHT_____ WEIGHT_____ lbs.

CURRENTLY EMPLOYED? ○ YES ○NO ○MODIFIED

REHAB INFORMATION

1. CHIEF COMPLAINT/AILMENT/INJURY
   _____
2. DATE OF INJURY_____DATE OF SURGERY_____
3. BRIEFLY DESCRIBE HOW YOU WERE INJURED.

_____

_____

4. HAVE YOU RECEIVED ANY PHYSICAL THERAPY THIS YEAR? ○YES ○ NO
   IF SO, WHEN?_____
5. HAS YOUR CONDITION BEEN GETTING: ○WORSE ○SAME ○BETTER
6. ARE YOUR SYMPTOMS: ○ CONSTANT OR ○ INTERMITTENT
7. MARK THE NUMBER THAT BEST CORRESPONDS TO YOUR PAIN:

AT BEST:	○0	○1	○2	○3	○4	○5	○6	○7	○8	○9	○10
AT WORST:	○0	○1	○2	○3	○4	○5	○6	○7	○8	○9	○10

8. WHAT DECREASESYOUR PAIN/MAKES YOUR CONDITION BETTER? (MARK ALL THAT APPLY)

□BENDING	□MOVEMENT	□REST	□BETTER IN AM
□SITTING	□STANDING	□HEAT	□BETTER AS DAY PROGRESSES
□RISING	□WALKING	□ICE	□BETTER IN PM
□CHANGING POSITIONS			
□LYING	□MEDICATION	□N/A CAST JUST REMOVED	

9. WHAT INCREASES YOUR PAIN/MAKES YOUR CONDITION WORSE? (MARK ALL THAT APPLY)

□BENDING	□MOVEMENT	□REST	□SNEEZE
□SITTING	□STANDING	□STAIRS	□DEEP BREATH
□RISING	□WALKING	□COUGH	□MEDICATION
□PROLONGED POSITIONING	□LYING	□WORSE IN AM	□WORSE IN PM
□WORSE AS DAY PROGRESSES		□N/A CAST JUST REMOVED	

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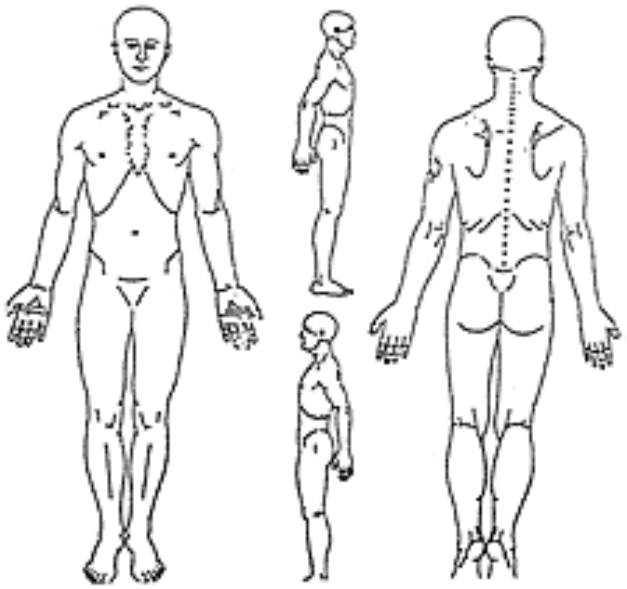
11. WHAT ARE YOUR GOALS TO BE ACHIEVED BY THE END OF THERAPY?

_____

_____

DRAW IN AREAS OF PAIN ON BODY DIAGRAM USING APPROPRIATE SYMBOLS.



SEVERE PAIN	**********
MODERATE PAIN	000000000000
DULL ACHE	∩∩∩∩∩∩∩∩
RADIATING PAIN	↑↓↑↓↑↓
NUMBNESS/TINGLING	xxxxxxxxxx

MEDICAL INFORMATION (MARK ALL THAT APPLY) **THIS INFORMATION IS CONFIDENTIAL AND REMAINS PART OF YOUR CHART.

□DIFFICULTY SWALLOWING
□ARTHRITIS
□HIGH BLOOD PRESSURE
□HEART TROUBLE
□PACEMAKER
□EPILEPSY/SEIZURES
□HISTORY OF DRUG ABUSE
□MYOFASCIAL PAIN
□CANCER
□MOTION SICKNESS
□FEVER/CHILLS/SWEATS
□UNEXPLAINED WEIGHT LOSS
□BLOOD CLOTS
□SHORTNESS OF BREATH
□HISTORY OF SMOKING
□DIABETES
□FIBROMYALGIA
□STROKE
□OSTEOPOROSIS
□ANEMIA
□BLEEDING PROBLEMS
□HIV/HEPATITIS
□HISTORY OF ALCOHOL ABUSE
□DEPRESSION/ANXIETY
□PREGNANCY