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?

Patient Name: _____

Please mark an "X" next to the statement below that best describes you:

_____ **The Internet (for example: Google, Yahoo, Bing)**

_____ **Yelp**

_____ **Newsletter**

_____ **Workshop**

_____ **Facebook** _____ **Instagram**

_____ **Family member/friend:** _____(Name)

_____ **Employee:** _____(Name)

_____ **My medical care provider**: _____(Name)

_____ **Yellow Pages**

_____ **Best of Long Island**

_____ **Shopping Cart**

_____ **Church Bulletin**

_____ **Other**: **Please describe** _____

_____ **I am a returning patient**.

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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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PATIENT INFORMATION SHEET

PERSONAL

Name_____ Date of Birth_____

Address_____City_____Zip_____

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

E-Mail Address_____ Employer_____

Address _____ Ph#_____

Emergency Contact_____ Ph#_____

Relationship_____

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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PATIENT CARE FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS

I hereby authorize and request that payment of authorized medical benefits be made on my behalf to Henry G. Purslow, P.T., P.C. d/b/a Farmingdale Physical Therapy West, for services rendered and/or furnished by a licensed physical therapist or physical therapist assistant employed by Henry G. Purslow, P.T., P.C (and/or Lake Shore Physical Therapy, 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 connection with my treatment is correct. I authorize any holder of Medical information about me to release to the applicable insurance company or provider any information needed to determine these benefits or the benefits payable for related services. 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. (and/or Lake Shore Physical Therapy, P.C.) may be in network with my health insurance. I hereby authorize Henry G. Purslow, P.T., P.C. (and/or Lake Shore Physical Therapy) to bill my insurance as out of network if my treating therapist is not in network with my insurance plan. I will 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. (and/or Lake Shore Physical Therapy, P.C.) will add a three (3)% charge on all past due balances, as well as the cost of any collections fees.

In the event of a same day cancellation or no show of a scheduled appointment, Henry G. Purslow, P.T., P.C. (and/or Lake Shore Physical Therapy, P.C.) reserves the right to charge a $15 cancellation/no show fee.

ASSIGNMENT OF MEDICARE BENEFITS

I request that payment of authorized Medicare benefits be made on my behalf to by Henry G. Purslow, P.T., P.C. (and/or Lake Shore Physical Therapy, P.C.) for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient Name (Print) _____

Patient Signature _____ Date_____

Parent/Guardian Name (Print) _____

Parent/Guardian Signature _____ Date_____
(If applicable)

Henry G. Purslow, P.T., P.C. Signature _____ Date_____

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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

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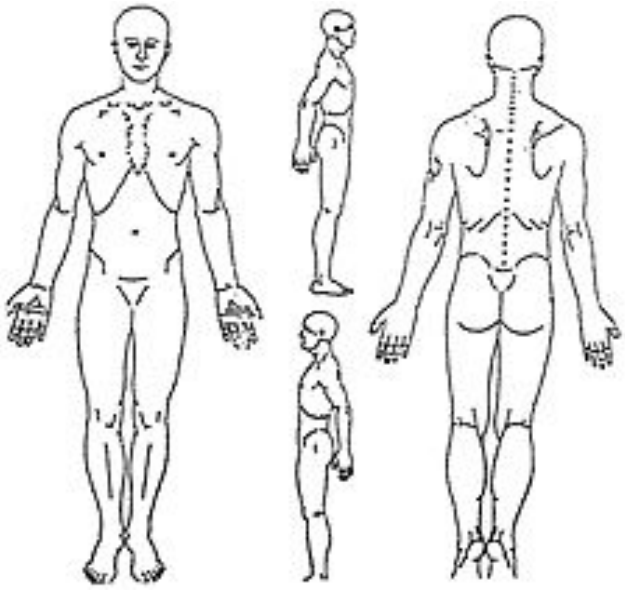
11. WHAT ARE YOUR GOALS TO BE ACHIEVED BY THE END OF THERAPY?

_____

_____

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



SEVERE PAIN	**********
MODERATE PAIN	0000000000
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