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 **ONE** of 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 THIS 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_____

Employment Status: (*circle*) Full Time Part Time Retired Unemployed Student (full time) Student (part time)

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 $20 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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PHYSICAL THERAPY INITIAL EVALUATION FORM

PATIENT INFORMATION

NAME_____ OCCUPATION _____

AGE_____ HEIGHT_____ WEIGHT_____ lbs.

LEFT HANDED OR RIGHT? _____

CURRENTLY EMPLOYED? ◯ YES ◯NO
ARE YOU CURRENTLY OUT OF WORK? ◯ YES ◯NO
ARE YOU RECEIVING SOCIAL SUPPORT? ◯ YES ◯NO
IF YES, SINCE WHEN? _____

REHAB INFORMATION

1. CHIEF COMPLAINT/AILMENT/INJURY

_____

_____

PLEASE INDICATE ONE OF THE FOLLOWING:

2. DATE OF ONSET/EXACCERBATION _____
   -OR-
3. DATE OR INJURY _____

4. ARE YOU POST OP? ◯ YES ◯ NO
   IF YES, WHAT IS THE DATE OF SURGERY? _____

5. BRIEFLY DESCRIBE HOW YOU WERE INJURED.

_____

_____

6. HAVE YOU RECEIVED ANY PHYSICAL THERAPY FOR THIS AILMENT PREVIOUSLY?
   ◯YES ◯ NO
   IF SO, WHEN? _____
7. HAS YOUR CONDITION BEEN GETTING: ◯WORSE ◯SAME ◯BETTER
8. ARE YOUR SYMPTOMS: ◯ CONSTANT OR ◯ INTERMITTENT

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9. PLEASE DESCRIBE YOUR SYMPTOMS:

◯ SHARP ◯ DULL ◯ SHOOTING ◯ THROBBING
◯ BURNING ◯ ACHY ◯ NUMBNESS ◯ TINGLING

10. 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
CURRENT LEVEL:	◯0	◯1	◯2	◯3	◯4	◯5	◯6	◯7	◯8	◯9	◯10

11. 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 □REACHING □CARRYING □LIFTING
□GRASPING □N/A CAST JUST REMOVED

□OTHER (EX: "IT HURTS FOR ME TO REACH INTO KITCHEN CABINET FOR A CAN OF SOUP")

_____

_____

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

_____

_____

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

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

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PRIOR AND CURRENT LEVEL OF FUNCTION

What are some activities of daily living that are affected by your condition?

ACTIVITY	FREQUENCY							DURATION	DISTANCE
	M	T	W	Th	F	S	S	How long would you do this activity on average each time?	How far do you go to do this activity?
Driving									
Walking									
Climbing									
Running									
Swimming									
Climbing Stairs									

ACTIVITY	FREQUENCY							DURATION	Please describe activity
	M	T	W	Th	F	S	S		
Exercising/Lifting									
Cleaning/Vacuuming									
Working									
Housework									
Cooking									
Daily Maintenance									
Showering/Bathing									TUB or WALK-IN SHOWER? (circle one)

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ACTIVITY	FREQUENCY							DURATION
	M	T	W	Th	F	S	S	
Maintaining Body Posture								
Grooming								
Dressing								
Oral Care								
Hand and Arm Use								
Fine Hand Use (Gripping)								
Reaching								
Sitting								
Writing								
Standing								
Sleeping								
Transferring (Lying to Sitting)								
Sit to Stand								

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FALLS EFFICACY SCALE

On a scale from 1 to 10, with 1 being very confident and 10 being not confident at all, how confident are you that you do the following activities without falling?

Activity	**Score: 1 = very confident** **10 = not confident at all**
Take a bath or shower	
Reach into cabinets or closets	
Walk around the house	
Prepare meals (not requiring carrying heavy or hot objects)	
Get in and out of bed	
Answer the door or telephone	
Get in and out of a chair	
Getting dressed and undressed	
Personal grooming (i.e. washing your face)	
Getting on and off the toilet	
TOTAL SCORE	

14. Have you had any recent falls (within the last 6 months?) ◯ YES ◯NO
    a) If yes, when? _____
    b) If yes, where? _____
15. Do you live alone? ◯ YES ◯NO
16. If no, do you live with a spouse? ◯ YES ◯NO
17. If no, do you live with children? ◯ YES ◯NO
18. Do you have steps to enter your home, or steps you must use within your home? ◯ YES ◯NO
    a) If yes, how many stairs? _____ How many railings? _____
19. Do you have steps or a ledge leading to the entrance of your shower? ◯ YES ◯NO
20. Do you have a walk-in shower or tub/shower combination? ◯ YES ◯NO

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PAIN DISABILITY INDEX

The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much your pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst. For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

Family/home responsibilities: This category refers to activities of the home or family. It includes chores or duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g. driving the children to school).

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Recreation: This category includes hobbies, sports, and other similar leisure time activities.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Social activity: This category refers to activities that involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Self-Care: This category includes activities, which involve personal maintenance and independent daily living (e.g. taking a shower, driving, getting dressed, etc.)

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Occupation: This category refers to activities that are a part of or directly related to one's job. This includes nonpaying jobs as well, such as that of a housewife or volunteer worker

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Sexual behavior: This category refers to the frequency and quality of one's sex life.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Life-support activity: This category refers to basic life-supporting behaviors such as eating, sleeping, and breathing.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

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MEDICAL HISTORY

Name: _____ Date: _____

Please Check or Circle Which Apply:

□ Congenital Heart Defect
□ Heart Problems/Heart Disease
□ Joint, Tendon, or Muscular Pain
□ Osteoporosis
□ Pacemaker
□ High or Low Blood Pressure
□ Chest Pain/ Angina/ Palpitations
□ Abdominal Pain/ Bloating/ Gas
□ Shortness Breath
□ Skin Problems
□ High Cholesterol
□ Dizziness/ Vertigo/ Fainting/ Blackouts
□ Liver Disease
□ Lung Disease
□ Diabetes (Type II)
□ COPD
□ Pain bowels/ Loose Stools/ Constipation
□ Coughing/ Wheezing or Exertion
□ Gout
□ Rheumatoid Arthritis
□ Anemia
□ Ulcers
□ Depression
□ Kidney Disease
□ Tuberculosis
□ Thyroid Problems
□ Psychological
□ Emphysema
□ Severe Headaches
□ Epilepsy/ Seizure Disorders
□ Sexually Transmitted Disease/ AIDS/ HIV
□ Allergies
□ Chemical Dependency (Alcoholism/ Illicit Substances)
□ Asthma/ Bronchitis/ Pneumonia/ Chronic Cough/ COPD
□ Stroke
□ Latex Allergy
□ Hepatitis A, B, C
□ Multiple Sclerosis
□ Cancer
□ Joint Replacement/ Repair
□ Gastrointestinal Issues
□ High or Low Blood Sugar
□ Poor Balance/ Recent Falls
□ Prostate Problems
□ Circulation Problems/ Blood Clots
□ Diabetes (Type I)
□ Lyme Disease

□ OTHER:
_____

_____

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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FAMILY MEDICAL HISTORY

For the following biological family members, please list any heath conditions (ex: diabetes, high blood pressure, asthma, cancer) they may have, even if the relative is deceased. (Insurance Requires Information)

Mother:

_____

_____

_____

Father:

_____

_____

_____

Brother(s):

_____

_____

_____

Sister(s):

_____

_____

_____

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FAMILY MEDICAL HISTORY (continued)

For the following biological family members, please list any heath conditions (ex: diabetes, high blood pressure, asthma, cancer) they may have, even if the relative is deceased. (Insurance Requires Information)

Grandmother (Mother's Side):

_____

_____

_____

Grandfather (Mother's Side):

_____

_____

_____

Grandmother (Father's Side):

_____

_____

_____

Grandfather (Father's Side):

_____

_____

_____

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Informed Consent for Physical Therapy Services

For physical therapy services, there are a wide range of treatment types and evaluations that can be used when it comes to treating and managing an assortment of conditions. Services are provided to patients of all ages regardless of color, ethnicity, gender, national origin, creed, disability, sexual orientation, age, gender identity, and/or socio-economic condition.

Physical therapy services can be used to treat various diseases, injuries, and disabilities by evaluation, diagnosis, prognosis, and intervention using rehabilitative procedures. Some of these procedures include mobilization, massage, exercises, and other physical means to aid the patient in achieving their individual, maximum potential within their able capabilities and to accelerate recovery and reduce the length of said functional recovery. All procedures will be explained to you before you are asked to perform them.

Response to physical therapy techniques can vary from person to person, and as such, we are unable to predict any single individual's response to a specific procedure, modality, or exercise protocol. Farmingdale Physical Therapy West cannot guarantee how you, as our patient, will react to a specific treatment type. We also cannot guarantee that the treatment we render will help resolve the condition that you are seeking treatment for. In extreme circumstances, there is a possibility that physical therapy treatment may result in aggravation of existing conditions and may cause further pain or injury.

It is your right to refuse any part of your treatment plan we have outlined at any time before or during your treatment, should you feel any pain or discomfort, or any other unresolved concerns. As part of your rights, you are entitled to ask your physical therapist about the treatment they have planned based on your individual history, diagnosis, symptoms and examination results. It is your right to discuss the potential risks and benefits involved in your treatment.

I, by signing this document, acknowledge that I have read this consent form and recognize the risks that are involved in physical therapy. By signing this document, I agree to fully cooperate and participate in all physical therapy procedures, and will comply with my established Plan of Care. I authorize the release of my medical information to appropriate third parties.

Patient's Name (Print): _____

Patient's Signature: _____

Date: _____

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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

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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Cash Pay for Alter-G, Laser, and Taping

Starting **August 20, 2018**, the following services will be charged out of pocket to our patients:

Alter-G:

Patients can purchase a package for $100.00 which would give them 10 intervals of 10 minutes.

Taping:

Patients can purchase a package for $75.00 which would give them 5 visits.

Laser:
Patients can purchase a package for $125.00 which would give them 5 visits.
SOME WORKERS COMP, NO FAULT, AETNA AND UNITED HEALTHCARE PATIENTS ARE THE ONLY EXCEPTIONS FOR LASER.

These are forms of treatment that your referring physician and/or physical therapist may find necessary for your treatment.

Thank you for your cooperation. If you have any questions, please inquire with the front desk.

Signature: _____ Date: _____

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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: _____