LAKE SHORE
Physical Therapy
www.LakeShorePhysicalTherapyNY.com

Phone: (631) 495-6179
Fax: (516) 731-3587
700-3 Union Parkway,
Ronkonkoma, NY 11779

Patient Survey

Patient Name: _____

*Please mark an "X" next to **ONE** of the statements below that best describes how you were referred to us:*

_____ **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**

_____ **I am a returning patient**.

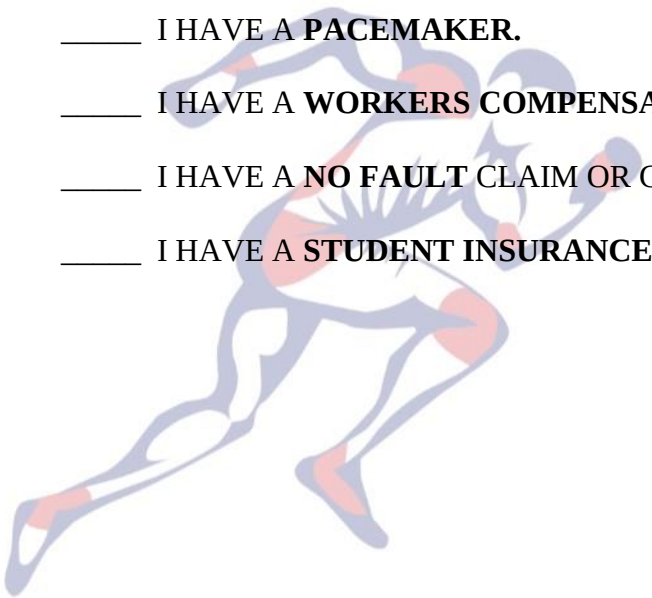
Just a few more questions:

_____ I HAVE A **PACEMAKER.**

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

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

_____ I HAVE A **STUDENT INSURANCE** CLAIM OR CASE.



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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_____

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#_____

Supplemental/Secondary_____ Name of Insured_____

Date of Birth_____ Relationship: self_____ spouse_____child_____ other_____

Social Security #_____ Employer_____ Ph#_____

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 and/or Lake Shore Physical Therapy, P.C., 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

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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.

Initials_____

Assignment of 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.

Initials_____

Out -of-Network Payment Agreement

If you are being treated by an Out-of-Network physical therapist, the insurance company may send a payment check directly to you; it is your financial responsibility to hand over the check along with a copy of the *Explanation of Benefits* to our office as soon as you receive the check. Failure to deliver us the payment will result in a bill for services rendered (up to $400 per visit).

Initials_____

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)_____ Date_____

Parent/Guardian Signature _____ Date_____
(If applicable)

Henry G. Purslow, P.T., P.C. and/or Lake Shore Physical Therapy, 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

_____

_____

2. PLEASE INDICATE ONE OF THE FOLLOWING:

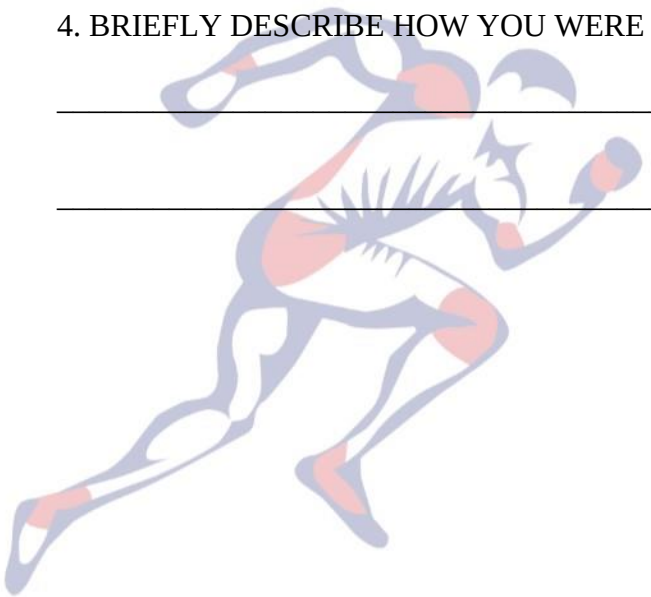
a. DATE OF ONSET/EXACCERBATION _____
-OR-
b. DATE OR INJURY _____

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

4. BRIEFLY DESCRIBE HOW YOU WERE INJURED.

_____

_____



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5. HAVE YOU RECEIVED ANY PHYSICAL THERAPY FOR THIS AILMENT PREVIOUSLY?
◯YES ◯ NO
IF SO, WHEN? _____

6. HAS YOUR CONDITION BEEN GETTING: ◯WORSE ◯SAME ◯BETTER

7. ARE YOUR SYMPTOMS: ◯ CONSTANT OR ◯ INTERMITTENT

8. PLEASE DESCRIBE YOUR SYMPTOMS:
◯ SHARP ◯ DULL ◯ SHOOTING ◯ THROBBING
◯ BURNING ◯ ACHY ◯ NUMBNESS ◯ TINGLING

9. 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

10. 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”)

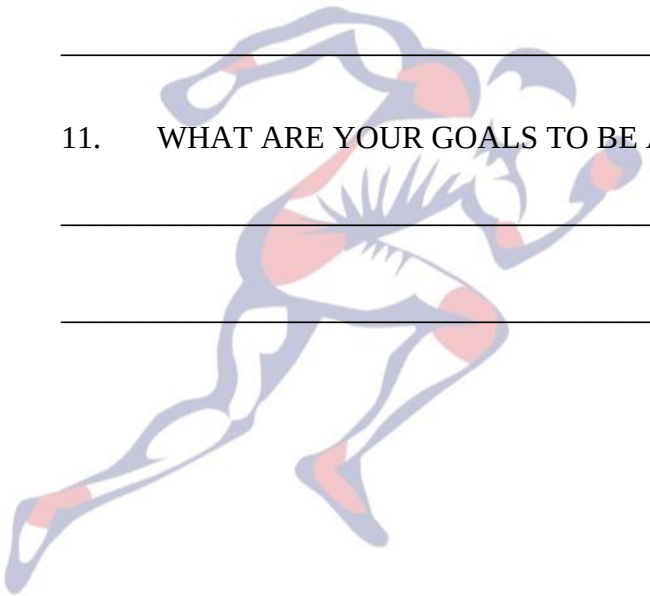
_____

_____

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

_____

_____



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

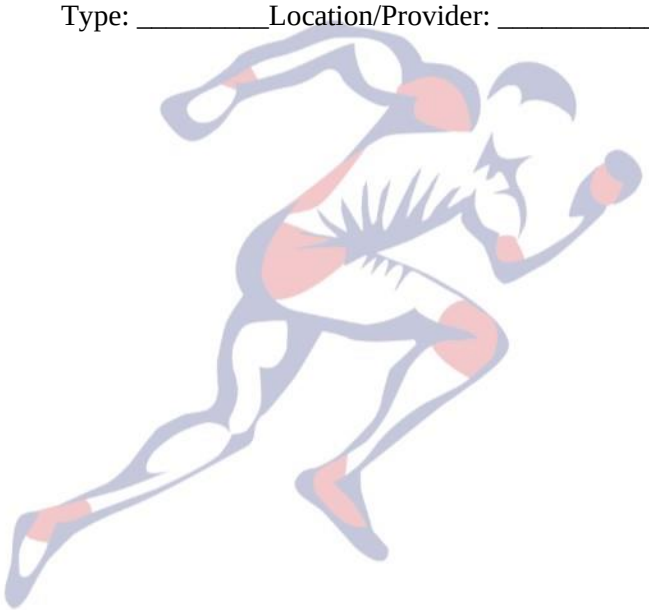
□ Congenital Heart Defect
□ Heart Problems/Heart Disease
□ Joint, Tendon, or Muscular Pain
□ Osteoporosis
□ Pacemaker
□ High or Low Blood Pressure
□ Chest Pain/ Angina/ Palpitations
□ Abdominal Pain/ Bloating/ Gas
□ Shortness Breath
□ Skin Problems
□ High Cholesterol
□ Dizziness/ Vertigo/ Fainting/ Blackouts
□ Liver Disease
□ Lung Disease
□ Diabetes (Type I)
□ Diabetes (Type II)
□ Pain bowels/ Loose Stools/ Constipation
□ 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
□ 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
□ COPD
□ Lyme Disease

13. **Medical Testing (MRI, CT Scan, X-Ray)**

Type: _____Location/Provider: _____ Date: _____

Type: _____Location/Provider: _____ Date: _____

Type: _____Location/Provider: _____ Date: _____



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MEDICARE PATIENTS ONLY

MY MEDICATION RECORD

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

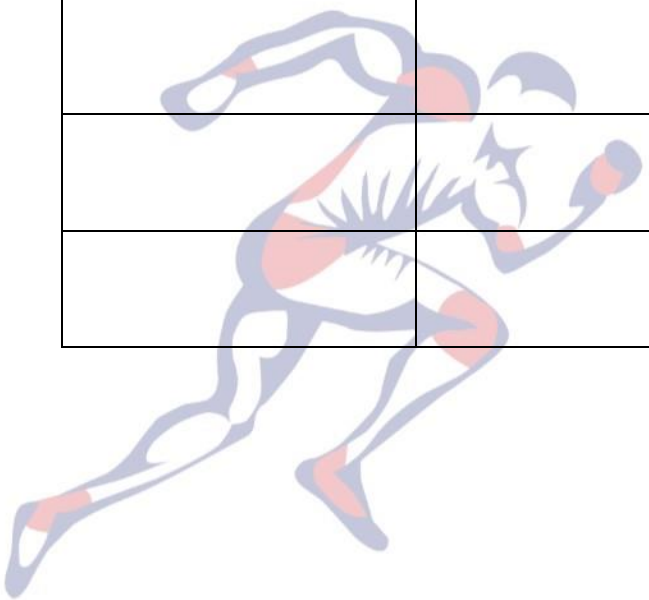
Patient name: _____ Date: _____

Allergies: _____

Pharmacy name: _____ Phone: (____) _____

Primary doctor name: _____ Phone: (____) _____

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



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Informed Consent for Physical Therapy Services & HIPAA Notice

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 (and/or Lake Shore Physical Therapy, P.C.) 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.*

I, _____, hereby authorize Henry G. Purslow, P.T., P.C., d/b/a/ Farmingdale Physical Therapy West (and/or Lake Shore Physical Therapy, P.C.), 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.

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I, _____ hereby authorize Henry G. Purslow, PT PC d/b/a Farmingdale Physical Therapy West (and/or Lake Shore Physical Therapy, P.C.), and its employees, including Henry G. Purslow, Vincenzo Adduci, Jillian Epifania, and Kristen Tasch 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 AUTHORIZATION IS BEING REQUESTED BASED ON THE NEW FEDERAL REGULATIONS THAT BECAME EFFECTIVE OCTOBER 2003 FOR ALL HEALTH CARE PROVIDERS**

_____ _____

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:

_____