

## 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** \_\_\_\_\_ **Yelp**

\_\_\_\_\_ **Family member/friend:** \_\_\_\_\_ (Name)

\_\_\_\_\_ **Employee:** \_\_\_\_\_ (Name)

\_\_\_\_\_ **My medical care provider:** \_\_\_\_\_ (Name)

\_\_\_\_\_ **Yellow Pages**

\_\_\_\_\_ **Best of Long Island**

\_\_\_\_\_ **I am a returning patient.**

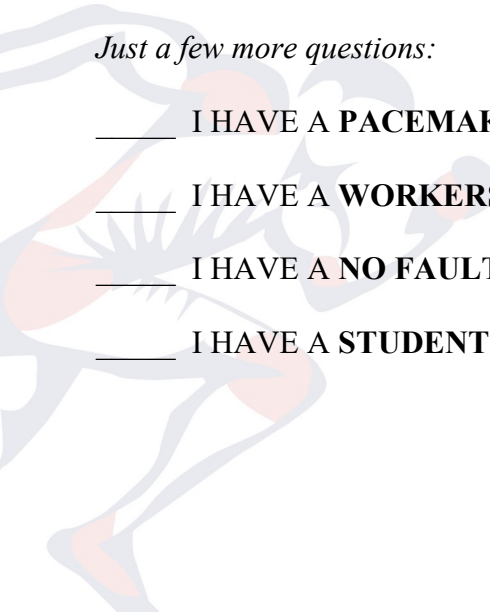
*Just a few more questions:*

\_\_\_\_\_ **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.**



**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 \_\_\_\_\_

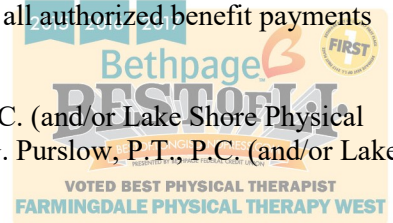
Date of Birth \_\_\_\_\_ Relationship: self \_\_\_\_\_ spouse \_\_\_\_\_ child \_\_\_\_\_ other \_\_\_\_\_

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 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 \$25 cancellation/no show fee.

### **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**

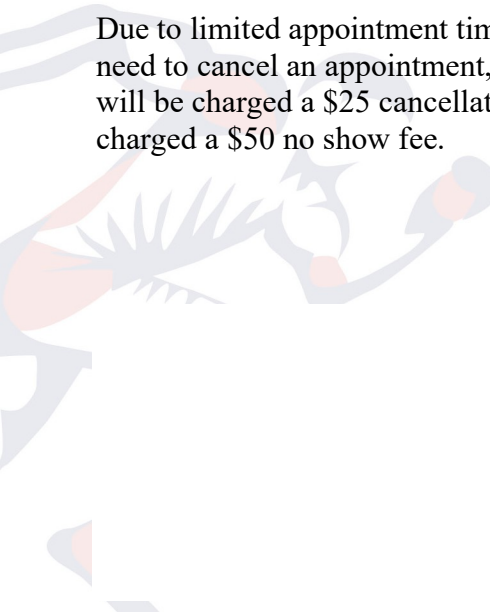
If you are being treated by an Out-of-Network physical therapist, the insurance company may send a payment check directly to you; it is your financial responsibility to hand over the check along with a copy of the *Explanation of Benefits* to our office as soon as you receive the check. Failure to deliver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

Initials \_\_\_\_\_

### **No Show/Cancellation Fee**

Due to limited appointment time slots, we are implementing the following no show/cancellation policy. If you need to cancel an appointment, you must cancel 24 hours before your scheduled appointment, otherwise you will be charged a \$25 cancellation fee. If you do not show up for your scheduled appointment, you will also be charged a \$50 no show fee.

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 \_\_\_\_\_

**PHYSICAL THERAPY INITIAL EVALUATION FORM****PATIENT INFORMATION**

NAME \_\_\_\_\_ OCCUPATION \_\_\_\_\_

AGE \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ lbs.

LEFTHANDED OR RIGHT? \_\_\_\_\_

CURRENTLY EMPLOYED?  YES  NOARE YOU CURRENTLY OUT OF WORK?  YES  NOARE 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/EXACERBATION \_\_\_\_\_
- 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  INTERMITTE

8. PLEASE DESCRIBE YOUR SYMPTOMS:

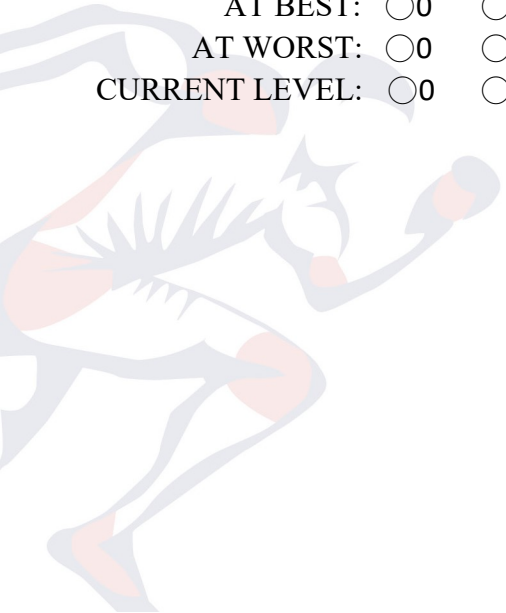
- SHARP
- DULL
- SHOOTING
- THROBBING
- BURNING
- ACHY
- NUMBNESS
- TINGLING

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)

- |  |  |                                      |                                      |
|--|--|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> BENDING                 | <input type="checkbox"/> MOVEMENT              | <input type="checkbox"/> REST        | <input type="checkbox"/> SNEEZE      |
| <input type="checkbox"/> SITTING                 | <input type="checkbox"/> STANDING              | <input type="checkbox"/> STAIRS      | <input type="checkbox"/> DEEP BREATH |
| <input type="checkbox"/> RISING                  | <input type="checkbox"/> WALKING               | <input type="checkbox"/> COUGH       | <input type="checkbox"/> MEDICATION  |
| <input type="checkbox"/> PROLONGED POSITIONING   | <input type="checkbox"/> LYING                 | <input type="checkbox"/> WORSE IN AM | <input type="checkbox"/> WORSE IN PM |
| <input type="checkbox"/> WORSE AS DAY PROGRESSES | <input type="checkbox"/> REACHING              | <input type="checkbox"/> CARRYING    | <input type="checkbox"/> LIFTING     |
| <input type="checkbox"/> GRASPING                | <input type="checkbox"/> N/A CAST JUST REMOVED |                                      |                                      |
- OTHER (EX: "IT HURTS FOR ME TO REACH INTO KITCHEN CABINET FOR A CAN OF SOUP")

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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.

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





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

Type: \_\_\_\_\_ Location/Provider: \_\_\_\_\_ Date: \_\_\_\_\_

Type: \_\_\_\_\_ Location/Provider: \_\_\_\_\_ Date: \_\_\_\_\_

Type: \_\_\_\_\_ Location/Provider: \_\_\_\_\_ Date: \_\_\_\_\_

**\*\*MEDICARE PATIENTS ONLY\*\***

MY MEDICATION RECORD

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

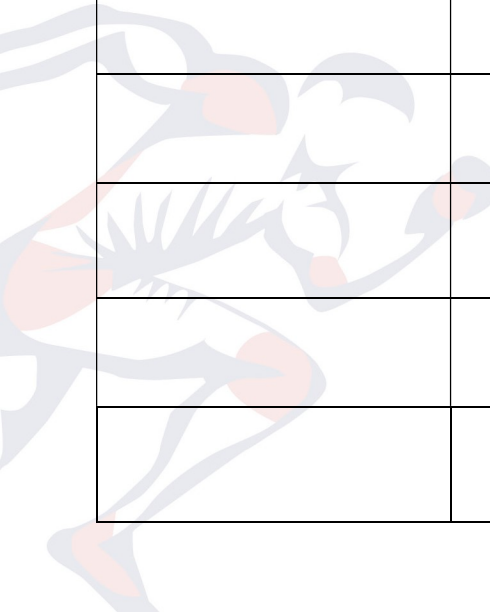
Patient name: \_\_\_\_\_ Date: \_\_\_\_\_

Allergies: \_\_\_\_\_

Pharmacy name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Primary doctor name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

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



**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. 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 HIPAA 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:

