Manhattan Sports & Manual Physical Therapy

The Caring Intelligent Touch

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WELCOME

ABOUT YOU

Today's Date: ___/____/_______

Patient Name: ____ ☐ Male ☐ Female

LAST FIRST MI

Name preference: ______________________ Birth date: ____/____/_____ SS#: ______-_____-________

Mailing Address: ____

APT CITY STATE ZIP

Home Phone #: ________________ Cell #: _____________Work #_______________ext______

E-Mail Address: _________________________________ Occupation: ____________________

Employer: ____________________Referred By: __________________ (☐ Doctor ☐ Friend ☐ Ins Co.)

STATUS: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Is this visit related to an accident? ☐ Yes ☐No Date of Accident ____/____/_____

If yes, is it? ☐ an auto accident ☐ work related ☐ slip & fall ☐other_____________________

(Auto accident) were you the, ☐ driver ☐ pedestrian ☐ passenger

Have you retained an attorney due to this accident? Name_________________________________

Address: ____ Tel #____________________

Other than No Fault/ Workers Comp or your primary ins, do you have a secondary insurance? ☐ Yes ☐ No

If yes, who is the guarantor? ☐Self ☐Spouse ☐Parent Name___________________ DOB: ____/_____/______

Ins Co_____________________Tel #_________________Policy # ___________________

Are you a dependent under the primary insurance (parents insurance) ☐ Yes ☐No If yes, please answer the following questions.

What school do you go to? ______________ Enrolled since _____/______/______ to ____/_____/_______

Employed? ☐ Yes ☐No If yes, do you have insurance through your employer? ☐ Yes ☐No *If yes, please give us a copy of card.*

IN EVENT OF EMERGENCY

Contact Name __________________________Home # _____________Work or cell # _____________

Who is your Medical Doctor? ___________________________ Phone #: ______________________

MEDICARE PATIENTS

Please let us know if you are enrolled in a managed care medicare program or a home health care program. This will allow us to bill the appropriate agency and avoid you from being financial liable for services rendered to you. **I am ☐ enrolled in a program ☐ not enrolled in a program**

HEALTH HISTORY

Are you taking any of the following medications?

☐ Nerve Pills ☐ Pain killers (including aspirin) ☐ Muscle relaxers ☐ Stimulants

☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Other(s) ______________________________

Do you have or ever had any of the following diseases or conditions?

Y N Heart Attack / Stroke
Y N Heart Surgery./Pacemaker
Y N Heart Murmur
Y N Congenital Heart Defect
Y N Mitral Valve Prolapse
Y N Artificial Valves
Y N Alcohol / Drug Abuse
Y N Venereal Disease
Y N Hepatitis
Y N HIV+ / Aids
Y N Shingles
Y N Cancer
Y N Frequent Neck Pain
Y N Emphysema / Glaucoma
Y N Anemia
Y N High/Low Blood Pressure
Y N Psychiatric Problems
Y N Rheumatic Fever
Y N Severe/Frequent Headaches
Y N Kidney Problems
Y N Ulcers / Colitis
Y N Fainting/Seizures/Epilepsy
Y N Sinus Problems
Y N Asthma
Y N Diabetes / Tuberculosis
Y N Difficulty Breathing
Y N Chemotherapy
Y N Lower Back Problems
Y N Artificial Bones / Joints
Y N Arthritis

Please list any other serious medical condition(s) you have or ever had:
____

Please list anything that you may be allergic to: ______________________________

List previous surgeries/treatment with dates: ______________________________

List any past serious accidents with dates: ______________________________

Family health History: ______________________________
____

Do You: Take Supplements or Vitamins? ☐Yes ☐ No / Exercise? ☐ Yes ☐ No

Are you on a special diet: ☐Yes ☐ No / Since: _____/_____/_____

Do you smoke? ☐No ☐ Yes / How Much? _______ How Long? ______

Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

For Women: Are you taking Birth Control? ☐ Yes ☐ No

Are you Pregnant? ☐ No ☐ Yes/ How long? _____ Nursing? ☐ Yes ☐ No

- We invite you to discuss with us any questions regarding our services. The best health services are based on understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid with in 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting you patient account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature ______________________________ Date ____________________
Adult Patient Parent or Guardian Spouse

Assignment of Benefits Form
Station Physical Therapy (DBA)
Manhattan Sports & Manual Physical Therapy, P.C.

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carriers payments.

Assignment of Benefits

I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including, Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to: Station physical Therapy, dba MSMPT, P.C. for medical services rendered to myself and/or dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize **Station Physical Therapy dba MSMPT, P.C.**: (1) release any medical information necessary to insurance carriers regarding y illness and treatments; (2) process insurance claims generated in the course of examination of treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from **Station Physical Therapy dba MSMPT, P.C.** on behalf of myself and /or my dependent, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date the services are rendered and I agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

______________________________ ____________________
Patient/Responsible Party Signature Date

______________________________ ____________________
Witness Date

LATE CANCELLATION/ NO SHOW POLICY

If you have to cancel a scheduled appointment we ask that you do so within 24hrs prior to your scheduled appointment, or **YOU** will be subject to a $55 late cancellation/no show fee. We ask that you do so in courtesy to your fellow clients who may use that time slot for their physical therapy treatment. This policy will help us to keep a more efficient schedule. If you fail to attend 3 scheduled appointments without prior notification MSMPT reserves the right to discharge you from your physical therapy program.

______________________________ ____________________
Patient Signature Date