

PATIENT INFORMATION			EMAIL ADDRESS: _____		
First Name:		Last Name:		Middle Initial:	Date: / /
Address:			City:		State: Zip:
Birth date: / /		Age:	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Home Phone: () -		Alternative Phone (Cell, Pager): () -		Spouse:	
Chose Clinic Because/ Referred to Clinic By <input type="checkbox"/> Dr.: <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Family <input type="checkbox"/> Friend					
<input type="checkbox"/> Former Patient <input type="checkbox"/> Close to Work/Home <input type="checkbox"/> Website <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Street Sign <input type="checkbox"/> Other:					
WORK INFORMATION					
Employer:			Work Phone () -		Ext.
Occupation:		Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Not Employed			
CARE PROVIDER INFORMATION					
Referring Dr:			Referring Dr. Phone: () -		
Regular Dr./PCP			Regular Dr./PCP Phone: () -		
INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)					
Primary Insurance Name:					
Subscriber's Name (If different):				Birth date : / /	
ID. #:		Group/Policy #			
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:					
Name of Secondary Insurance:					
Subscriber's Name:				Birth date : / /	
ID. #:		Group/Policy #			
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:					
AUTO OR WORK INJURY CLAIM (PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)					
Insurance Name: <input type="checkbox"/> Auto : <input type="checkbox"/> Labor & Industries:					
Adjuster/Claim Manager:			Phone:		Ext.:
Address:		City:		State:	Zip:
Claim #:		Accident Date: / /		Cause:	
ATTORNEY INFORMATION					
Name:		Law Firm:		Phone: () -	
Address		City		State:	Zip:
IN CASE OF EMERGENCY					
Name of Local Friend or Relative:					
Relationship to Patient:		Home Phone: () -		Work Phone: () -	

I authorize my insurance benefits be paid directly to Achieve Physical Therapy & Aquatic Therapy. I understand that I am financially responsible for any balance. I also authorize to Achieve Physical Therapy & Aquatic Therapy to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE

DATE



Medical History Form

Patient Name: _____ Height _____ Weight: _____

Past/Present Medical Conditions (Check Yes or No)					
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Circulatory Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Metal/Other Implant	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Multiple Sclerosis (MS)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nervous Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eating Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Numbness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pregnancy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fainting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fatigue	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fever/Chills/Sweats	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Night Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shortness of Breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nausea/Vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dysuria	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bowel Dysfunction	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Urinary Frequency Changes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Unexplained Weight Change	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Have you had any medical problems or hospitalizing in the past year? Yes No

If "yes", please specify: _____

Surgical History: Procedure/Date: _____ Procedure/Date: _____

Medications Currently Taking: _____

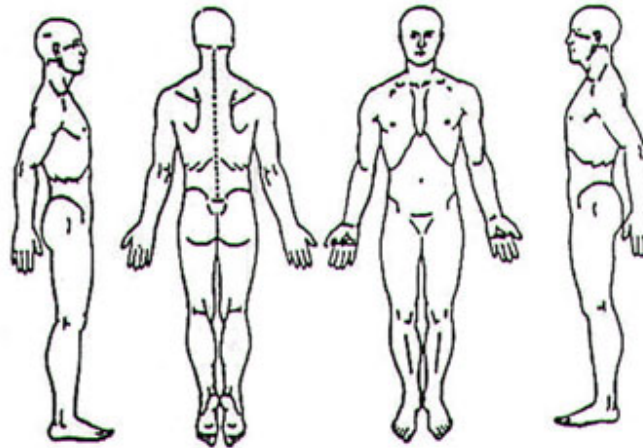
Exercise:	<input type="checkbox"/> None	<input type="checkbox"/> 1-2x/wk	<input type="checkbox"/> 3-4x/wk	<input type="checkbox"/> 5+ x/wk
Work Activity:	<input type="checkbox"/> Sitting	<input type="checkbox"/> Standing	<input type="checkbox"/> Light Labor	<input type="checkbox"/> Heavy Labor
Stress Level:	<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High	
Habits:	<input type="checkbox"/> Smoking	# Cigs per day: _____		
	<input type="checkbox"/> Alcohol	# Drinks per week: _____		
	<input type="checkbox"/> Coffee/Soda	# Cups per week: _____		

Have you had Physical Therapy before? Yes No

If "yes", when? _____

Achieve Physical Therapy
Medical History Form (Page 2)

Please circle or shade where you are experiencing pain:



CURRENT Pain Level (circle one):

0	1	2	3	4	5	6	7	8	9	10
No pain	Mild, annoying pain	Nagging, uncomfortable, troublesome pain	Distressing, miserable pain	Intense, dreadful, horrible pain	Worst possible, unbearable, excruciating pain					

BEST Pain Level (circle one):

0	1	2	3	4	5	6	7	8	9	10
No pain	Mild, annoying pain	Nagging, uncomfortable, troublesome pain	Distressing, miserable pain	Intense, dreadful, horrible pain	Worst possible, unbearable, excruciating pain					

WORST Pain Level (circle one):

0	1	2	3	4	5	6	7	8	9	10
No pain	Mild, annoying pain	Nagging, uncomfortable, troublesome pain	Distressing, miserable pain	Intense, dreadful, horrible pain	Worst possible, unbearable, excruciating pain					

Patient Signature: _____ Date: _____

Achieve Physical Therapy and Aquatics
4654 Onondaga Boulevard, Suite 1 - Syracuse, NY 13219

General Request for Service, Release of Information, Personal Effects and Financial Authorization

- I.** I hereby voluntarily consent to such evaluation procedures and therapy and to such medical and diagnostic tests, as is necessary in the judgment of the Physical Therapist. I state that I have read and understand the following authorization and that I understand why the described treatment is necessary.
- II.** I hereby release Achieve Physical Therapy from all liability resulting from loss or damage to any personal effects retained by me on arrival or received by me. This includes, but not limited to, jewelry, eyeglasses, electrical devices, clothing, and any other personal item(s).
- III. A. Authorization for Release of Information by Achieve Physical Therapy**
I hereby authorize and direct the above names facility, having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my treatment and medical care, all information needed to substantiate payment for such treatment and medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.
- B. Assignment to Achieve Physical Therapy**
I hereby irrevocably assign, transfer, and set over to the above named facility sufficient monies and/or benefit to which I may be entitled from governmental agencies, insurance carriers or others who are financially liable for my treatment and medical care to cover the costs of the care and treatment rendered to myself or my dependent in said facility.
- C. Guarantee of Payment to Achieve Physical Therapy**
I request Achieve Physical Therapy to furnish all services and treatments as may be recommended or directed by the patient's physician. I acknowledge receipt of the same, and I agree to pay charges therefore, based on rates in effect at your facility. I understand that services may not be covered under my insurance. I also understand that I may be liable for payment of services not covered under my insurance. *****NOTICE OF ADVISE: The notice of advice advises the patient that the treatment may not be covered by their specific health care plan or insurer without a referral. I understand that services may not be covered under my insurance. I also understand that I may be liable for payment of services not covered under my insurance and it is my responsibility to understand my physical therapy benefits, eligibility and coverage.**

(Initials)

D. For Patients Entitled to Medicare Benefits

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for therapy services to Achieve Physical Therapy or authorize such entity or corporation to submit a claim to Medicare for payment to me.

(Initials)

E. I have been provided with a copy of this document to retain for my future reference.

(Initials)

- IV.** I have been offered the HIPAA information as provided by Achieve Physical Therapy. I have read the above certifications, or they have been read to me and I fully understand them.

Patient's Signature (Parent or Guardian if
Minor) or Authorized Representative

Date/Time

Achieve Physical Therapy
Representative

Achieve Physical Therapy and Aquatics
4700 Onondaga Blvd.
Syracuse, NY 13219

POLICY ON SCHEDULED APPOINTMENTS

Dear Patient:

This is to inform you of Achieve Physical Therapy's policy regarding keeping scheduled appointments. Due to treatment schedule, you must notify us 24 hours before your scheduled appointment if you are unable to attend your therapy session. Should you fail to contact us, we reserve the right to personally bill you \$30.00 for appointments missed.

Please sign below indicating you have been informed of our policy.

We thank you for your cooperation in this manner.

***PLEASE NOTE: That if you are being treated under Worker's Compensation or No Fault, failure to attend Physical Therapy appointments may be viewed, by the carrier, as being non-compliant and may be considered grounds for a reduction in allowed benefits.**

Patient's Signature: _____

Date: _____



I acknowledge that I have been given the opportunity to read/ or receive a copy of Achieve Physical Therapy's Privacy notice.

Person(s) authorized to receive/discuss my health information:

Name

Relationship

Signature

Date