ProActive Physical Therapy & Sports Rehabilitation, PLLC

465 COLUMBUS AVENUE, SUITE 130, VALHALLA NY 10595 **TEL: (914) 741-2850** **FAX: (914) 741-2851**

PATIENT INFORMATION

Date: _____

Name: First _____ MI ____ Last _____ **Gender: [ ]** F **[ ]** M

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Phone: [ ] Home _____ **[ ] Mobile** _____

(Please check preferred phone where we can leave a detailed message with patient information during business hours)

E-Mail: _____ **Occupation:** _____

DOB: ____ / ____ / _____ **SSN:** _____ **Marital Status: [ ] Single [ ] Married [ ] Other**

Emergency Contact: _____ **Relation:** _____ **Phone:** _____

Worker's Compensation or No Fault:
Are you seeing treatment for a condition related to a work or auto injury? **[ ] Yes [ ] No**

Primary M.D.: _____

Referring M.D.: _____

INSURANCE INFORMATION

Primary Insurance: _____

Member ID#: _____

Subscriber: _____ **DOB:** _____

Financially Responsible: _____

Secondary Insurance: _____

Member ID#: _____

Subscriber: _____ **DOB:** _____

[ ] Self Relation: _____

CONDITIONS OF TREATMENT & FINANCIAL POLICY

PATIENT RESPONSIBILITY: As a patient receiving medical care, I am aware of my insurance coverage and limitations. It is my responsibility to determine insurance benefits and provide ProActive Physical Therapy & Sports Rehabilitation, PLLC with correct billing information. I will assist with obtaining necessary pre-authorization when needed as failure to obtain this may result in a reduction or rejection of benefits by the insurance company. I will be responsible for any deductible, copayments, or other patient balances due and payable upon receipt of a monthly statement. Payment options include cash or check. I understand that past due accounts may be assigned to an outside agency for collection. I have had an opportunity to ask questions and accept the responsibility of these terms.

CONFIDENTIALITY/RELEASE OF MEDICAL INFORMATION: Your medical history and personal information will be held in strict confidence. Your case will only be discussed or shared for purposes of necessary communication with your physician or to satisfy requirements for payment. A detailed copy of our Privacy Policy is available upon request.

ASSIGNMENT OF BENEFITS & RELEASE OF MEDICAL INFO: I hereby authorize payment of medical benefits to ProActive Physical Therapy & Sports Rehabilitation, PLLC for services rendered to my dependents or myself. I also authorize the release of any medical information that is necessary to process insurance claims. I understand that I am responsible for any amount not covered by insurance. I certify that the information I provide is true and correct to the best of my knowledge. I give my permission to the practitioner to administer and perform such procedures as may be deemed necessary for treatment.

NO SHOW/CANCELLATION POLICY: ProActive Physical Therapy & Sports Rehabilitation, PLLC reserves the right to charge a $75 fee for patients who do not show up to a scheduled appointment or cancel less than 24 hours in advance. This fee will not be billed to or covered by your insurance.

Patient/Guardian Signature: _____ **Date:** _____

ProActive Physical Therapy & Sports Rehabilitation, PLLC **HEALTH HISTORY FORM**

Name: _____ Age: _____ Date: _____

Date of last complete medical examination: _____ Performed by: _____

Are you currently receiving ANY form of Home Health Care? [ ] Yes [ ] No For?_____

Next scheduled Dr. appointment(s): Date _____Physician _____

When did the condition you are coming for start? _____

(Provide specific or approximate date of injury or onset of pain.)

Did you have surgery? [ ] Yes [ ] No Date:_____ Procedure: _____

Did you have the following tests? [ ] Xray [ ] MRI [ ] CT Scan [ ] EMG Other: _____

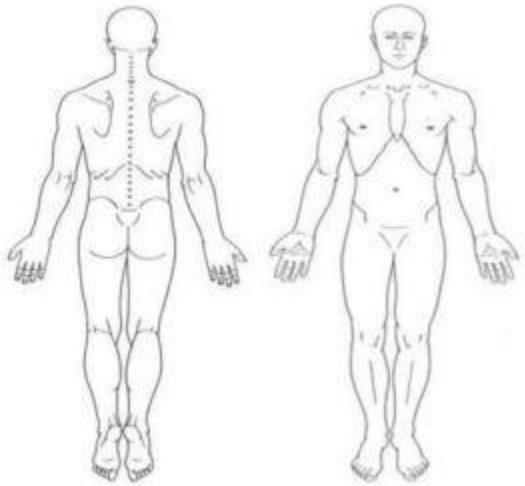
Are you currently taking any medications? [ ] Yes [ ] No (Please list below or bring medication list)

_____ _____ _____ _____

Do you have PAIN? If so draw on the BODY CHART where your pain is located.

What does your pain feel like? (check all that apply):
[ ] Sharp [ ] Burning [ ] Aching [ ] Tingling [ ] Numbness

Other: _____



Does pain radiate to arms or legs? [ ] Yes [ ] No

Does pain keep you up at night? [ ] Yes [ ] No

RATE YOUR PAIN: _____ (0=none, 10=severe)

What makes your pain worse? (check all that apply)
[ ] Lying Down [ ] Sitting [ ] Standing [ ] Walking Other _____

What eases your pain? (check all that apply)
[ ] Lying Down [ ] Sitting [ ] Standing [ ] Walking Other _____

Recent weight loss or gain? [ ] Yes [ ] No Height _____ Weight _____ BMI _____

Do you exercise when injury free? [ ] Yes [ ] No Are you pregnant? [ ] Yes [ ] No

Were you in a Motor Vehicle Accident? [ ] Yes [ ] No Date of accident: _____

Do you now or have you had any of the following: (check all that apply)

[ ] Heart Disease	[ ] Diabetes	[ ] Allergies	[ ] High Blood Press	[ ] Asthma
[ ] Heart Attack	[ ] Pacemaker	[ ] Kidney Problem	[ ] Headaches	[ ] Thyroid Issues
[ ] Cancer	[ ] Hernia (any)	[ ] Shortness of Breat	[ ] Nervous Disorder	[ ] Previous Surgery
[ ] Stroke	[ ] Dizziness	[ ] Infectious Disease	[ ] Seizures	[ ] Metal Implants

If YES to any of the above please give details and approximate dates: _____

Are there any other conditions we should be aware of? _____

**If there are any medical history issues you prefer not to list, please speak directly with your Physical Therapist.

All statements above are true to the best of my knowledge _____

Patient Signature and Date

ProActive Physical Therapy & Sports Rehabilitation, PLLC

MEDICATION LIST

****Required for all Medicare & Medicare Advantage Plans**

Name: _____ **Date:** _____

Please include all prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary supplements.

MEDICATION	DOSAGE	FREQUENCY	ROUTE OF ADMINISTRATION (oral, injection, spray, et)