SOUTH JEFFERSON
PHYSICAL THERAPY

307 Riverside Drive
Clayton, NY 13624
Phone: 315-285-5159 Fax: 315-285-5160
sjpt@sjphysicaltherapy.com

Patient Information

Last Name: _____ First Name: _____ MI: ____

SSN: _____ Date of Birth: _____ Gender: M F

Address: _____ Address 2: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Preferred Method of Appointment Reminder: Text or Email

Emergency Contact/Designated Party - to share information and/or make appointments on behalf of

Last Name _____ First Name_____

Relationship _____ Phone _____

Primary Insurance

Insurance _____ ID_____

Subscriber Name & DOB _____ Relationship to Subscriber_____

Copay_____ Coinsurance _____ Deductible _____

Secondary Insurance

Insurance _____ ID_____

Subscriber Name & DOB _____Relationship to Subscriber_____

Copay_____ Coinsurance _____ Deductible _____

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Workers Compensation Claim? ***If yes, then*** Date of Injury: _____

WCB Number:_____Carrier: _____ Claim #: _____

Claim Adjuster's Name and Phone:

_____

Employer Name _____

Phone _____

Employer Address _____City_____State_____Zip_____

Motor Vehicle Accident? *If yes, then* Date of Accident: _____

Carrier:_____Claim #: _____

Adjuster's Name and Phone Number: _____

PEDIATRIC PATIENTS

Primary Parent or Guardian: _____ DOB:_____SS#: _____

Relationship to Patient: _____Address same as patient? Y / N

If no – Street: _____ City: _____

State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Alternate Parent or Guardian: _____ DOB:_____SS#: _____

Relationship to Patient: _____Address same as patient? Y / N

If no – Street: _____ City: _____

State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

If you would like someone other than yourself to bring your child for treatment, we MUST have the necessary release form completed by the patient's legal guardian.

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Name: _____ **Date:___/_____/___**

Your current limitation and date your problem began:

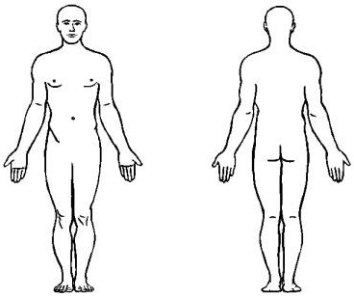
_____

_____

Did you have surgery? Y/N Specific Date:_____

Referring Provider Name:_____

Please indicate where your pain is located



Please describe the nature of your pain:

__Sharp Pain
__Dull Ache
__Throbbing
__Numbness
__Shooting
__Burning
__Tingling

__Constant (76%-100%)
__Frequent (51%-75%)
__Occasional (26%-50%)
__Intermittent (25% or less)

Please indicate the intensity of your *pain at rest*: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable pain)

Please indicate the intensity of your *pain with movement*: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable pain)

Since your condition began, have your symptoms: __Decreased __Not changed __Increased

Your symptoms are worse in: __Morning __Afternoon __Night __Increase during the day __Decrease during day __Same all day

Have you been treated for this condition in the past? __Yes __No ***If Yes, what treatment did you receive and when?***

_____

Has your work status changed because of this condition? __Yes __No
Are you currently receiving home health services? __Yes __No

Any history of the following

__ High blood pressure
__ Angina
__ Heart attack
__ Stroke
__ Asthma
__ HIV/AIDS
__Cancer, Location _____
__ Lupus
__ Hepatitis
__Epilepsy
__Diabetes
__Rheumatoid Arthritis
__Arthritis
__Pregnancy_____
__Tobacco, Pack/Day ____
__Drug or Alcohol Dependence
__Anxiety or Depression
__Seizures __Thyroid Disorder __High Cholesterol __Other

Hospitalizations/Surgical Procedures:

_____
_____
_____
_____
_____
_____
_____

Medication List/Allergies:

_____
_____
_____
_____
_____
_____

Present Weight: _____ **Height:** _____

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General Consent for Treatment, Authorization and Assignment of Benefits, Binding Insurance, Release of Records, Cancellation Policy, Privacy Policy Consent

General Consent for Treatment

I, the patient, enter South Jefferson Physical Therapy clinic voluntarily for the purpose of diagnosis and medical treatment. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of diagnosis, treatment, test, or examinations performed at South Jefferson Physical Therapy. I have received a copy of the South Jefferson Physical Therapy Joint Notice of Privacy Practices. I give my permission for the clinic to use my name in the general course of treatment on patient boards. I agree that the clinic shall not be liable for loss or damage to any personal property.

Authorization of Release of Information & Assignment of Benefits/ Payment Guarantee/ Binding Insurance

The clinic may disclose all or any part of my/ the patient's record to any person or corporation which may be liable under contract to the clinic for all or parts of the clinic charges. Including but not limited to, hospital or medical service companies, billing, insurance companies, workers compensation carriers, welfare funds or my/the patient's employer. The clinic may disclose my Social Security number to any State or Federal government agencies, as required by law. I assign and instruct my insurance company (ies) to pay South Jefferson Physical Therapy directly for services rendered. I request that payment of authorized benefits be paid on my behalf. I understand that I am financially responsible for charges that are not covered by this assignment, Including, but not limited to, collection fees/costs, credit card machine fee, no show fees and cancellation fees. Information given to South Jefferson Physical Therapy will be binding throughout patient treatment. This information including insurance company (ies) responsible for payment for services rendered. If the responsible insurance company changes throughout treatment, patients must notify South Jefferson Physical Therapy immediately. Changes will take place at the time we are notified. Changes cannot be applied retroactively to previous dates of service.

Medicare Certification

I certify that the information given to me in applying for payment under the title XVII of the Social Security act is correct. I authorize any holder of information about me to release Social Security Administration, or its intermediaries or carriers, any information needed for claims. I request that payment or authorized benefits be made on my behalf.

Cancellation Policy

Please note, due to the high number of incoming clients, our $25.00 Late Cancellation Fee and $40.00 No Show Fee will be strictly enforced. This cost is not covered by insurance. If you expect to arrive more than ten minutes late, please call ahead to confirm your appointment with our staff. Any patient arriving more than ten minutes late without contacting the office may not be able to be accommodated for that date. A pattern of three or more such instances may result in a discharge. If you are not able to make your appointment, please contact us at least 24 hours in advance. If you need to cancel after hours, we have an answering machine where you can leave a message.

←THIS FORM IS FRONT AND BACK →

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Privacy Policy Consent

This notice was published and becomes effective on/or before June 1, 2003. We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at Clinic Phone # (315)232-2225.

Print Name:_____ Date:_____

Signature:_____ Relationship to Patient:_____
(If not self)

←THIS FORM IS FRONT AND BACK→