Riverdale Sports Physical Therapy

531 w. 235th st
Bronx, NY 10463
718-432-1323

Patient Intake Information OON:

Name:

Sex: Male / Female Date of Birth:

Address:

Home Phone Number: Cell Phone Number:

We ask our patients to please provide us with a valid email as we will be sending emails to patients in regards to our practice:

Email Address:

Emergency Contact Name: Relationship:

Emergency Contact Phone:

Doctor's Name?

Your Place of Employment? How did you hear about us?

I certify that the above information is complete and accurate.

Patient/Guardian Signature: **Date:**

Confidential Health History

Please check all symptoms you currently have or had in the past year.

GENERAL

□ Fever
□ Chills
□ Sweats
□ Headache
□ Dizziness
□ Fainting
□ Forgetfulness
□ Depression
□ Loss of sleep
□ Loss of weight
□ Nervousness
□ Numbness

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

□ Head
□ Neck
□ Shoulders
□ Arms
□ Hands
□ Back
□ Hips
□ Knees
□ Feet

EYE, EAR, NOSE, THROAT

□ Crossed eyes
□ Blurred vision
□ Double vision
□ Vision – Flashes or Halos
□ Bleeding gums
□ Earache
□ Ear discharge
□ Ringing in ears
□ Loss of hearing
□ Nosebleeds
□ Sinus problems
□ Hay fever
□ Hoarseness
□ Persistent cough
□ Difficulty swallowing

CARDIOVASCULAR

□ High blood pressure
□ Low blood pressure
□ Chest pain
□ Rapid heart beat
□ Irregular heartbeat
□ Poor circulation
□ Varicose veins
□ Swelling of ankles

GENITO-URINARY

□ Blood in urine
□ Frequent urination
□ Painful urination
□ Lack of bladder control

GASTROINTESTINAL

□ Poor Appetite
□ Bloating
□ Bowel changes
□ Constipation
□ Diarrhea
□ Excessive hunger
□ Excessive thirst
□ Gas
□ Hemorrhoids
□ Indigestion
□ Nausea
□ Rectal bleeding
□ Stomach pain
□ Vomiting
□ Vomiting blood

Please check all conditions you currently have or had in the past year.

□ Arthritis
□ Asthma/Bronchitis
□ Cancer
□ Cataracts
□ Diabetes
□ Emphysema
□ Epilepsy
□ Gout
□ Heart Disease
□ Hepatitis
□ Hernia
□ High Cholesterol
□ Migraine Headaches
□ Multiple Sclerosis
□ Pacemaker
□ Pneumonia
□ Polio
□ Stroke

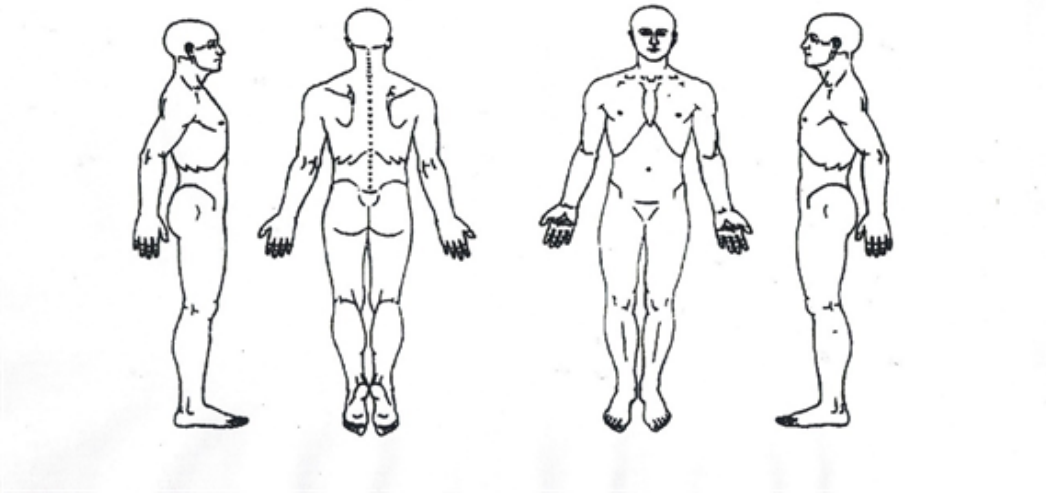
Patient/Guardian Signature: **Date:**

Patient Health Report

A. Draw today's symptoms on the figure:

Shade in all areas of pain. Grade the intensity of pain in each area using 0 - 10 scale:

0 = no pain / no discomfort, 10 = the worst pain you can imagine



B. Identify the intensity of your symptoms.

Please circle one of the numbers to show the amount of pain you are experiencing today:

C. Please list any recent surgery dates. Describe any changes in your condition or any new concerns. You may also list your current medications.

Patient/Guardian Signature: **Date:**

HIPAA Privacy Rule and Notice of Privacy Practices

This notice describes how protected health information (PHI) may be used and disclosed and how you can get access to this information. Sycamore Physical Therapy is required by law to protect the privacy of health information that may reveal your identity and to provide you with a copy of this notice which describes the health information privacy practices of our facility, staff and affiliated health care providers that jointly perform payment activities and business operations with our facility. Protected health information (PHI) is information about you, including present or future physical or mental health or conditions, and related health care services.

In compliance with HIPAA (The Health Insurance Portability and Accountability Act), Sycamore Physical Therapy will not disclose your protected health information (PHI) without your explicit authorization, except as permitted by law for the purposes of payment, treatment and health care operations. Furthermore, Sycamore Physical Therapy will limit the use, disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. This notice refers to Sycamore Physical Therapy as "us" and "our," and to the patient/guardian as "I," "my," "you," "your," and "yourself."

If you choose to have your PHI communicated to individuals other than yourself or those mentioned above, please accurately complete and submit a medical records request form to Sycamore Physical Therapy. You further agree to be responsible for notifying Riverdale Sports Physical Therapy if you wish to revoke or change these authorizations.

Federal Laws effective April 14, 2003 require patients to be given a notice of privacy policy formulated in accordance with HIPAA (The Health Insurance Portability and Accountability Act) and to sign a consent form and payment agreement. New York State Law requires all alternative healthcare practitioners to inform patients that they should consult western medical practitioners in regard to the condition for which they seek treatments.

Cancellations & No Shows

Cancellations must be made 12 hours in advance of the scheduled appointment time.

There is a $25 fee if your appointment is cancelled less than 12 hours prior to the appointment time. There is a $50 fee if you No Show your appointment.

The insurance company will not be charged for your missed appointment; you will be responsible for this payment out-of-pocket. Please be courteous to your Physical Therapists and fellow patients by arriving on time for your appointments.

Patient/Guardian Signature: **Date:**

Payment Contract

As a courtesy, we contacted your insurance company to inquire about your physical therapy benefits. Below is a summary of the information we were given. We strongly recommend that you also contact your insurance carrier and confirm your benefits as we are sometimes given incorrect information. Sycamore Physical Therapy is not responsible for any inaccurate information we receive and will bill you for any balances that your insurance company indicates as your responsibility. Please let us know if you have any questions about your coverage.

Payment is requested at the time of your visit.

Patient is responsible for:

_____

_____

_____

_____

I (patient/guardian) hereby authorize direct payment of medical benefits to Sycamore Physical Therapy (provider) for services rendered by provider in person or under provider's supervision. I understand that I am financially responsible for any balance not covered by my insurance. I certify that the information given by me in applying for payment is correct. I authorize the release of all records on request. I request that payment of authorized benefits be made on my behalf.

I acknowledge and agree to abide by the Out of Network benefit policies above.

It is my responsibility to make these payments without any need for periodic bills or other reminders of payments due.

Patient/Guardian Signature: **Date:**

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Out of Network Policy Holders

Your health insurance is out of network with our office. As a courtesy to our patients, Sycamore Physical Therapy will bill your insurance for services rendered in our office so you do not have to submit your own claims. **Your insurance does not make or send any payment directly to our office; they will reimburse you, the patient, for the treatments you received at our office via check to your home. When you receive payment, you will be responsible for remitting this payment to our office within 15 days to avoid additional charges which may include legal fees.** We also ask that you bring all explanation of benefits forms (EOBs) to our office (typically attached to the checks) when remitting payment to our office.

Please bring checks and EOBs to the front desk.

If our office does not receive any information (checks, EOBs) from you, the policy holder, or your insurance company within 60 days of billing, you will be responsible for the total amount billed. Please fill out the form below if you would like to put a credit card on file.

Name (as it appears on card): Credit Card Number:

Expiration Date: Security Code: Zip Code:

(Circle one): Visa Mastercard American Express Discover

I (credit card holder) authorize Sycamore Physical Therapy to charge my credit card for services rendered if payment is not remitted to their office 60 days from the date of service was billed.

Financial Hardship

I hereby certify that I have been informed of the usual fees for the examination, testing and treatment that have been recommended. I have no expectation of being able to recover those expenses from a third party. If I am unable to pay all fees in full at this time without incurring substantial financial hardship, the provider may agree to accept payments toward the total amount required by my insurance company. To enable me to obtain the recommended services, Sycamore Physical Therapy and I have agreed to a payment arrangement (financial hardship payment agreement) under which I will pay the amount specified in this contract.

I understand my financial responsibility and agree to the terms stated in this contract. I will return checks and EOBs to Sycamore Physical Therapy in a timely manner for services rendered.

Patient/Guardian Signature: **Date:**

Physical Therapy Services

Have you had Physical Therapy Services at any other facility within this calendar year?

Yes or No

If yes, what is the name of the facility?

Approximately how many times were you seen there?

Patient/Guardian Signature: **Date:**

Occupational Therapy Services

Have you had Occupational Therapy Services at any other facility within this calendar year?

If yes, what is the name of the facility?

Approximately how many times were you seen there?

Patient/Guardian Signature: **Date:**

Non-discrimination Policy

RIVERDALE PHYSICAL THERAPY/SYCAMORE PHYSICAL THERAPY shall operate in a manner that does not unlawfully discriminate against people on the basis of race, color, national origin, religion, sex (including pregnancy) age, sexual orientation (including gender identity and expression), marital status, disability, veteran status, or any other basis prohibited by federal, state, or local law. RSPT and SPT prohibits retaliation against any person because he or she opposed or complained about discrimination in good faith, assisted in good faith in the investigation of a discrimination complaint, or participated in a discrimination charge or other proceeding under federal, state, or local anti-discrimination law.

2/28/13

I confirm that I have read, understand and agree to the above policy

Patient/Guardian Signature: **Date:**

Sycamore Physical Therapy
3050 Corlear Ave Suite 102A
Bronx, NY 10463
718-708-6853

PATIENT QUESTIONNAIRE

Have you or any of your immediate family members come in contact with anyone who has tested positive for COVID-19?
YES OR NO

Have you had any COVID-19 symptoms or tested positive in the last two weeks?
YES OR NO

If yes, have you had any follow up testing?
YER OR NO

If so, what were the results?
_____

When was your last follow up test?
_____

Do you currently have any flu like symptoms (related or unrelated to COVID-19)
YES OR NO

Patient Signature: Date:

_____