Alden
PHYSICAL THERAPY

12845 Broadway St, Suite 2
Alden, NY 14004
p: (716) 902-5068
f: (716) 902-4050

Patient Information

Name: _____ Today's Date: _____/_____/_____

Address: _____ SSN: _____-_____-_____
City: _____ State: _____ Zip: _____ DOB: _____/_____/_____

Primary Phone: (_____)_____-_____ Secondary Phone: (____)____-_____
Email: _____

Emergency Contact Person: _____ Phone: (____)____-_____

Referring Physician: _____ Primary Physician:
_____

Insurance Information **ID Number**
Primary Insurance: _____ _____
Secondary Insurance: _____ _____

Worker's Comp Information (if applicable)
Employer: _____ Phone: (_____)_____-_____
Insurance Carrier Phone: (____)____-_____
Case Manager: _____ Phone: (_____)_____-_____

No Fault Information (if applicable)
Insurance Carrier: _____
Insurance Address: _____
Insurance Phone: (____)____-_____
Contact Name: _____
Claim #: _____

Have you had **Outpatient Physical Therapy** since January 1st of this year? ☐ YES ☐ NO
If yes: Where?: _____
When?: _____
What body part?: _____

Signature: _____ Date: ____/____/____

Name: _____ Today's Date: _____/_____/_____

Past Medical History: _____

_____

Past Surgical History: _____

_____

Do any of the following apply to you? (please circle):
Diabetes / Arthritis / Metal Implants / Pacemaker / Cancer / Pregnant

Any diagnostic tests?: CT Scan / MRI / Xray / EMG/NCVT / Bone Scan
Results: _____

Any allergies? ☐ YES ☐ NO If yes, what?: _____

Please list any medications: _____

_____

What body part are you here for?:
☐ Neck / ☐ Back / ☐ Shoulder / ☐ Elbow / ☐ Wrist / ☐ Hand / ☐ Hip / ☐ Knee / ☐ Ankle
Other: _____

How and when did your symptoms start?: Approximate date: ____/____/____
☐ Work / ☐ Car Accident / ☐ Slip/Fall / ☐ Surgery / ☐ Unknown
Other: _____

Please describe your injury: _____

_____

What problems are you experiencing?:
☐ Pain / ☐ Stiffness / ☐ Weakness / ☐ Swelling / ☐ Poor Balance / ☐ Numbness / ☐ Difficulty Walking
Other: _____

Have you had a similar injury before?: ☐ YES ☐ NO If yes, describe: _____

_____

Please **RATE YOUR PAIN:**

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10

Describe your pain:

☐ Sharp / ☐ Dull / ☐ Achy / ☐ Shooting / ☐ Burning / ☐ Constant / ☐ Intermittent
Other: _____

Where are your symptoms now?: _____

What makes your symptoms better?: _____

What makes your symptoms worse?: _____

Alden Physical Therapy, PC

Insurance Co-Pay Authorization

I, _____, being a member of _____ understand and
(Patient's Name) (Insurance Carrier)

agree to pay the co-payment/coinsurance of _____ each time physical therapy services are rendered to myself or my child by Alden Physical Therapy, PC.

Deductible Information (if applicable):

Deductible: _____
Deductible Met: _____
Deductible Remains: _____

_____
_____
_____

Cancellation/No Show/Late Policy:

We realize that circumstances outside of your control arise on occasion, and we will take this into consideration before accessing any late/no show fees.

If you should need to cancel an appointment, we require 24 hour notice; otherwise you will be charged a **$25.00 cancellation fee.**
If you do not show up for your scheduled appointment and have not called to cancel, you will be charged a $50.00 **no show fee.**
If you are 15 or more minutes **late**, we cannot guarantee you will be treated, and may have to reschedule your appointment.
If you miss **three consecutive appointments**, we may need to discontinue your treatment.

I understand that the billing of insurance companies is a courtesy, and that I am financially responsible for payment at the time that services are rendered. If I do not provide the correct information required for billing, I will be personally responsible for all expenses associated with the services rendered. Expenses may include interest charges, collection fees, and legal/court costs. I hereby give my permission to Alden Physical Therapy, PC to administer treatment for my condition and authorize Alden Physical Therapy, PC to release all necessary medical records to parties responsible for payment. I also understand that, in some situations, I may receive physical therapy without a prescription from my physician; however, my insurance company may not pay for these services if a prescription is not provided.

_____ ____/____/____
(Signature) (Date)

Alden
PHYSICAL THERAPY

12845 Broadway St, Suite 2
Alden, NY 14004
p: (716) 902-5068
f: (716) 902-4050

Acknowledgment of Receipt of Privacy Notice

I have been provided with access to a copy of Alden Physical Therapy's **Notice of Privacy Policies,** detailing how my health information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice. I understand that my medical records will be sent to my **referring physician** and to my **insurance company.** I also request that the following individuals have access to my medical records:

_____
_____
_____
_____

Further, I permit a copy of this authorization to be used in place of the original.

May we phone, email, or send a text to you to confirm your appointments? ☐ YES ☐ NO

May we leave a message on your answering machine at home? ☐ YES ☐ NO
on your cell phone? ☐ YES ☐ NO

PRINT PATIENTS' NAME: _____

SIGNED: _____ DATE: ___/___/___

Relationship (if signed by other than patient): _____

(OFFICE USE ONLY)

If patient's representative refused to sign the **acknowledgment of receipt of privacy notice,** please document the date/time the notice was presented to the patient and sign below:

Presented on (date & time): _____
By (name of personnel): _____