

CARPENTER

PHYSICAL THERAPY

NEW PATIENT CHECKLIST

PLEASE BRING THE FOLLOWING WITH YOU TO YOUR FIRST APPOINTMENT:

- 1. Your completed new patient forms*
- 2. The prescription from your Doctor*
-Some insurance companies require a referral from your Primary Care Physician
- 3. Your Insurance Card*
-One of our staff members will call your insurance company to verify your benefits prior to your appointment as a courtesy to you. We want to ensure our patients have a firm understanding of what is their payment responsibility for their medical care.
- 4. Your Driver's License*
- 5. Your Co-Pay or Payment*
-Payment is expected at the time services are rendered.
-We accept cash, check, Visa, MasterCard and Discover
- 6. Any written reports of test results you may have had*
-Such as x-rays, MRI's and Nerve Conduction Studies.
- 7. Please wear comfortable clothing, loose exercise-oriented clothing.*
-T-shirts, sweatpants and sneakers are recommended.
-If you are coming to us for a knee or lower extremity condition, please bring a pair of shorts.

*If you have any questions or need to change your appointment, please contact us at
518-623-3410*

**P.O. Box 452 Warrensburg, NY 12885
Phone: 518.623.3410 * Fax: 518.338.0125**

Patient Name: _____

Address: _____

Phone # _____

DOB: ____ / ____ / ____

Emergency Contact: _____ Relationship: _____ Phone: _____

Are you the subscriber on the insurance policy? Yes / No (please circle, if no please complete below)

Name of Insured: _____ DOB: ____ / ____ / ____

Social Security # _____ Your relationship to insured: _____

General Questions:

Are you Right Handed Left Handed

Do you have any custom or religious beliefs that may effect your care?

No Yes. _____

Have you undergone Physical Therapy services in the past year? _____

Home Situation:

Where do you live?

Private Home Private Apartment Rented Home Group Home Long Term Care Facility
 Hospice Assisted Living Homeless Other: _____

With Whom do you Live?

Alone Spouse Only Spouse and others Child Other relatives Group setting
 Personal Care attendant Other: _____

Does your home have stairs to enter?

No Yes Railings? No Yes I have a Ramp Elevator

How many? _____

If rails are present, where are they?

One on the right going up One on the left going up Both sides and they are close enough so I can grab both Both sides, but I cannot reach both at the same time Other: _____

I use the following equipment:

standard walker electric wheelchair roller walker manual wheelchair cane none
 Other: _____

I work

full time part time outside my home from home homemaker retired student unemployed

Job title: _____

Employer: _____

Health History

Please rate your general health:

Excellent Good Fair Poor

Have you had any major life changes during the last year? (ex. Job change, death of a family member, etc.)

No Yes Please Explain: _____

How often do you exercise beyond normal daily activities? _____

If you smoke, how many packs per day? _____

If you drink, how many days per week? _____ How many drinks per day? _____

Please report any family history of:

- a. Heart Disease _____
- b. Hypertension _____
- c. Stroke _____
- d. Diabetes _____
- e. Cancer _____
- f. Other _____

Please list the prescription medications you are taking: (or attach a list)

Please list the non prescription medications you are taking: (ex, pain, antacids, antihistamines, herbal supplements, anti inflammatory)

Please list any surgeries you have had and include details:

Do you have any allergies?

No Yes _____

Current Problem

Please describe your chief complaint

When did this begin? _____

Have you had this problem before? _____ If yes, what did you do for it? _____

Did the problem get better? No Yes If yes, about how long did the problem last? _____

How are you taking care of the problem now? _____

What makes the problem worse? _____

What makes the problem better? _____

What activities are you unable to do now, that you could do before the problem? (Please be specific as possible: for instance “unable to reach over my head”)

Are you seeing anyone else for this problem? (ex. Chiropractor, Massage therapist, Doctor)

Please list recent medical tests that you have undergone. (EKG, MRI, X-ray, blood)

Health History(please check if you have ever had the following)

- Allergies
- Arthritis
- Blood disorder
- Broken Bones/fx
- Cancer
- Circulation/Vasc problems
- Depression
- Development or growth problems
- Diabetes
- Female Problems
- Head Injury
- Heart problems
- High blood pressure
- Infectious disease(TB, Hepatitis,etc)
- Stomach problems
- Fibromyalgia

- Kidney problems
- Low blood pressure
- Hypoglycemia
- Lung problems
- Multiple Dystrophy
- Osteoporosis
- Pacemaker
- Parkinson’s disease
- Repeated infections
- Seizures/Epilepsy
- Skin disease
- Prostate disease/males
- Stroke
- Thyroid problems
- Other: _____

Current Limitations: (Check all that apply)

Difficulty with:

- Locomotion/movement Bed mobility Transfers (bed to chair, bed to commode)
- Gait (walking) ___ on level ground ___ on stairs ___ on ramps ___ on uneven ground
- Self Care (bathing, dressing, etc) Home management (household chores, shopping, driving)
- Community and work activities
- Work/School
- Recreation/play activities

Patient Signature: _____

Date: _____

Provider Signature: _____

Date: _____

CARPENTER PHYSICAL THERAPY, PLLC
28 Hudson Street
Warrensburg, NY 12885
(518) 623-3410

PATIENT NAME: _____

PATIENT ADDRESS: _____

CONSENT TO PHYSICAL THERAPY EVALUATION and TREATMENT AT CARPENTER PHYSICAL THERAPY CLINIC: I hereby request and authorize medical treatment recommended by my referring physician or by self-referral. The undersigned consents to treatment of Physical Therapy under the general and special instructions of the referring physician or under the New York State Direct Access Law.

NOTICE OF ADVICE FOR SELF-REFERRED PATIENTS:

I have been informed of the possibility that physical therapy treatment may not be covered by my health care insurer without the referral of a physician, dentist, podiatrist, or nurse practitioner, but may be a covered expense, if treatment was rendered pursuant to such referral.

Treatment will begin on: _____
Date

Therapist Name: _____ License # _____

Therapist Signature: _____ Date: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION and PAYMENT OF BENEFITS: I hereby authorize **CARPENTER PHYSICAL THERAPY, PLLC** to disclose all or any parts of my medical record requested by the insurance company, its designated agent, or liable third parties to include Medicare, worker's compensation carrier, employer, case manager, and attorney whose benefits have been assigned for purposes of benefit payment. **I hereby authorize payment** directly to Carpenter Physical Therapy, PLLC of all insurance benefits otherwise payable to me for services rendered. **I have been provided** with a copy of Carpenter Physical Therapy's Privacy Policy and understand how they will handle my protected health information.

I further authorize the transfer of copies of my medical records to the referring physician, the patient and any health care facility or physician, which I transfer. I also give Carpenter Physical Therapy, PLLC **permission to obtain** any medical or billing records from an insurance carrier, legal office, or other medical facility.

X

Signature of Patient or Authorized Representative

Witness

Date



Financial Policy

Thank You for choosing Carpenter Physical Therapy! We are committed to the success of your care. Please understand that payment of your bill is part of this treatment and care. The information below is provided as a courtesy to clarify your financial responsibility related to professional services provided by Carpenter Physical Therapy. This document does not cover all situations and should not be construed to be an all-inclusive listing of all possible situations.

Your financial responsibility depends on a variety of factors, explained below

| If You Have... | You Are Responsible For... | Our Staff Will... |
|---|--|---|
| Insurance Plan with whom we are in network. | Patient portion (co-pays, deductible, co-insurances, etc.) are due on the day of your appointment. | Contact your insurance plan to obtain your eligibility, benefit information and patient portion (co-pays, deductibles, co-insurance, etc.) Submit your insurance claim. |
| Insurance Plan with whom we are not an "In-Network" Provider. | Payment in full on or before your appointment, Unless your plan agrees to pay us directly. | Contact your insurance plan to obtain your eligibility and Out-of-Network benefit information. Submit your insurance claim. |
| Medicare | If you have Medicare we ask that you pay your annual deductible and/or 20% portion once we have received payment from Medicare. If you have Medicare and have a secondary form of insurance (including Medicaid), most times no action is needed. | Contact your insurance plan to obtain your eligibility, benefit information and patient portion (co-pays, deductibles, co-insurance, etc.) Submit your insurance claim If you have a secondary form of insurance, most times Medicare will submit balance directly to them. |
| Medicare Managed Care Plan (Senior Blue, MVP Gold, BlueShield of Northeastern NY.) | Patient portion (co-pays, deductible, co-insurances, etc.) are due on the day of your appointment. | Contact your insurance plan to obtain your eligibility, benefit information and patient portion (co-pays, deductibles, co-insurance, etc.) Submit your insurance claim. |
| Worker's Comp | No patient responsibility. | We will contact your comp carrier and obtain authorization for PT visits. |
| No Fault Auto Insurance | No patient responsibility. | We will contact and submit claims to your Insurance company. |
| No Insurance | Payment in full due on day service is provided. | Advise you regarding charges for services. |
| | | |

We accept payment by: Cash, Check, Credit Card (Visa/Mastercard/Discover) Charges not covered by your insurance plan, as well as applicable co-payments and deductibles, are your responsibility. Our return check fee is \$25.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures We will use your protected health information (PHI) for the purposes of treatment, payment and health care operations.

Treatment includes the disclosure of health information to other providers who have referred you for services or are involved in your care. This may include doctors, nurses, technicians, and other physical therapists. For example, we may feel that a stroke patient we are treating would benefit from an evaluation by a speech-language pathologist to address a swallowing difficulty. The health information we share with the speech-language pathologist would be considered a treatment related disclosure.

Payment includes the disclosure of health information to your insurance company, including Medicare and Medicaid, so payment can be obtained for services rendered. Your insurance company may make a request to review your medical record to determine that your care was necessary.

Health Care Operations includes the utilization of your records to monitor the quality of care being given at our facility or for business planning activities.

Other Special Uses

Our practice may use your PHI to send you an appointment reminder, to inform you of our other health-related products and services, or to request a contribution to our charitable activities.

Uses and Disclosures Required by Law

The federal health information privacy regulations either permit or require us to use or disclose your PHI in the following way: we may share some of your PHI with a family member or friend involved in your care if you do not object, we may use your PHI in an emergency situation when you may not be able to express yourself, and we may use or disclose your PHI for research purposes if we to do so by law, for example by court order or subpoena. Disclosures to health oversight agencies are sometimes required by law to report certain diseases or adverse drug reactions.

We may use and disclose health information about you to avert a serious threat to your health or safety or the health or safety of the public or others. If you are in the Armed Forces, we may release health information about you when it is determined to be necessary by the appropriate military command authorities. We may also release information about you for workers' compensation or other similar programs that provide benefits for work-related injury or illness.

Your authorization is required before your PHI may be used or disclosed by us for other purposes.

**2) Your Privacy Rights
Restrictions**

You have the right to request restrictions on how your PHI is used, however, we are not required to agree with your request. If we do agree, we must abide by your request.

Confidential Communications

You have the right to request confidential communication from us at a location of your choosing. This request must be in writing.

Access to PHI

You have the right to request a copy of your medical record. You must make this request in writing and we may charge a fee to cover the costs of copying and mailing.

Amendments

You have the right to request an amendment be made to your PHI, if you disagree with what it says about you. This request must be made in writing. If we disagree with you, we are not required to make the change. You do have the right to submit a written statement about why you disagree that will become part of your record. We may not amend parts of your medical record that we did not create.

Accounting of Disclosures

After April 14, 2003, you have the right to request an accounting of the disclosures made in the previous six years. These disclosures will not include those made for treatment, payment, or health care operations or for which we have obtained authorization.

Complaints

If you feel that your privacy rights have been violated, you have the right to make a complaint to us in writing without fear of retaliation. Your complaint should contain enough specific information so that we may adequately investigate and respond to your concerns. If you are not satisfied with our response, you may complain directly to the Secretary of Health and Human Services.

Our Duty to Protect Your Privacy

We are required to comply with the federal health information privacy regulations by maintaining the privacy of your PHI. These rules require us to provide you with this document, our Notice of Privacy Practices. We reserve the right to update this notice if required by law. If we do update this notice at any time in the future, you will receive a revised notice when you next seek treatment from us.

(If you plan to post this notice on your practice website, you can put in the address here.)

Privacy Contact

If you would like more information about our privacy practices or to file a complaint you may contact:

Name: Amanda Carpenter

Title: Physical Therapist/Owner

Address: P.O. Box 452

Warrensburg NY, 12885

Phone: (518) 744-9095

Effective Date: April 14, 2003