Bronx Physical Therapy, LLP
3611 E. Tremont Avenue
Bronx, NY 10465

Patient Information

Patient Information

Patient Name: _____ DOB: _____ Sex: _____

Marital Status: _____ SSN: _____

Home Phone: _____ Cell: _____

Address: _____

Employer: _____ Position: _____

Employer Address: _____ Phone No. _____

Emergency Contact Information

Dependent? _____ If yes, Guardian's Name: _____

Guardian's Phone: _____ Cell: _____

Marital Status: _____ Spouse's Name: _____

Spouse's Employer: _____ Work Phone No. _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell: _____

Insurance

Insured Party: _____ Relationship to Patient: _____

Insurance Company: _____ DOB: _____

Address: _____

Member #: _____ Group No. _____

Dual Coverage? _____ 2nd Insurance Company: _____

Insured Party: _____ Relationship to Patient: _____

Phone No. _____ DOB: _____

Member #: _____ _____

TO MY INSURANCE CARRIER

1. I authorize the release of any medical information necessary to process my claim(s) to: BRONX PHYSICAL THERAPY, LLP
2. I authorize and request payment of medical benefits to my physicians at BRONX PHYSICAL THERAPY
3. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me
4. I agree that a photocopy of this form may be used in lieu of the original
5. I agree to pay all charges not covered by my insurance carrier(s). These charges include but are not limited to deductibles, co-insurance and copays

_____ _____

Patient Date

REVISED 3/2022

Physical Therapy Intake Form

Personal Information

Name: _____ Date: _____

Address: _____

Phone: _____ Email: _____

DOB: _____ Sex: _____

Who referred you? _____

History

Exercise Frequency: _____ Exercise Type(s): _____

Do you smoke? _____ Have you ever smoked? _____ How Often? _____

Are you pregnant? _____ Do you have a Pacemaker? _____

Allergies: _____

What medications are you currently using? _____

Previous complaints/surgeries: _____

Previous diagnoses/medications: _____

Complaint

What is your major complaint? _____

Start Date: _____ Possible Cause: _____

Symptoms: _____

Previous doctors seen for complaint: _____

Previous treatment for complaint: _____

Symptom-Aggravating Factors: _____

Symptom-Relieving Factors: _____

Time of Day Symptoms are Best: _____ Time They Are Worst: _____

Current Duration of Pain: ☐ Intermittent ☐ Constant ☐ With Certain Motions

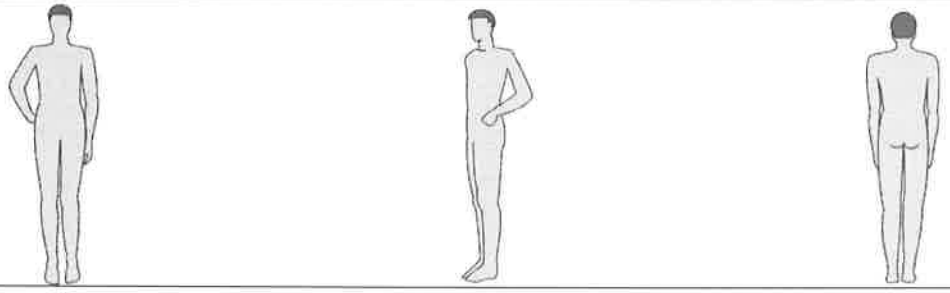
Current Level of Pain: ☐ Mild ☐ Moderate ☐ Severe ☐ Excruciating

Is your pain getting better or worse? _____ Have you had this injury before? _____

Do You Have Any of the Following Today? (Check All That Apply)

☐ AIDS/HIV	☐ Anemia	☐ Angina	☐ Arteriosclerosis
☐ Arthritis	☐ Asthma	☐ Blood Clots	☐ Bone Infection
☐ Cancer	☐ Chemical Dependency	☐ Circulation Problems	☐ Depression
☐ Diabetes	☐ Epilepsy	☐ Eye Infection	☐ Heart Problems
☐ Hemophilia	☐ High/Low Blood Pressure	☐ Joint/Bone Infection	☐ Liver Problems
☐ Lung Issues	☐ Multiple Sclerosis	☐ Musculoskeletal Problems	☐ Pneumonia
☐ Stroke	☐ STD	☐ Tuberculosis	☐ Urinary Infection

Mark Areas of Discomfort



_____ _____

Signature Date

Pain Level Chart

You can describe your pain to the healthcare provider using any of the choices given below:

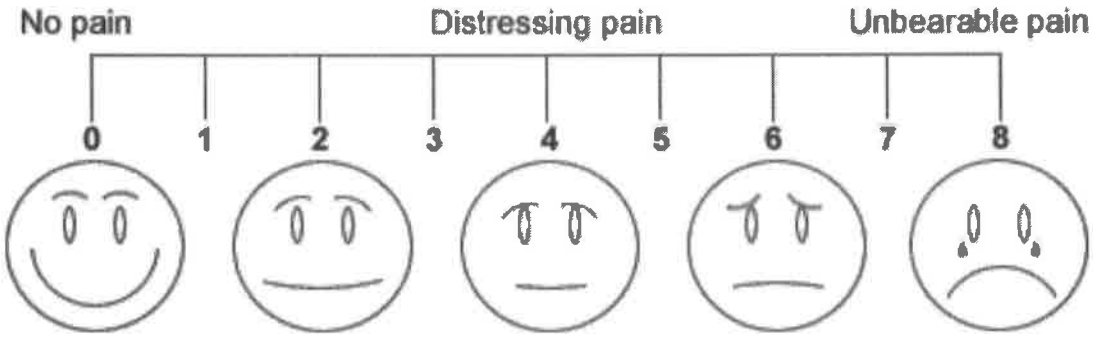
Type of pain (Tick as applicable)

☐ Throbbing
☐ Stabbing
☐ Dull
☐ Aching
☐ Pinching
☐ Steady
☐ Localized
☐ Pervasive
☐ Chronic (persistent)
☐ Acute (in the moment)

Other comments / Notes: _____

_____

Use the chart below to estimate your pain level



Other comments / Notes: (Include details on time when you felt the pain as well as activities that triggered the pain.)

Bronx Physical Therapy, LLP

Registered Physical Therapists

"YOUR COMFORT IS OUR CONCERN"

- Have you had Physical or Occupational Therapy prior to coming to our office this year? YES _____ NO _____
- If yes, what insurance did you use? Medicare, Commercial, Workers Comp, No Fault
- What body part was treated? _____
- If yes, how many TOTAL visits did you have at the previous facility? _____
- What is the name and phone number of the Physical Therapy Office?

  _____
- Was it in-patient or out-patient physical Therapy? _____
- Have you had or currently have Home Health Care? _____
- Is this a work related or a motor vehicle injury? _____
- Did you file a claim with Workers Comp or No Fault? _____
- Do you have any other INSURANCE COVERAGE? Yes ____ No ____
- Have you or are you being treated for Occupational Therapy, Pain Management, Chiropractic or Massage Therapy? (If so, you **CANNOT** do both on the same day, if you do, your insurance will **NOT COVER BOTH VISITS** and you will be responsible for payment! Yes ____ No ____
- If any of your information changes during your treatment, i.e., address, phone number, insurance, **it is your responsibility to notify us immediately**, or **YOU** will be responsible for all charges incurred.

Signature: _____ **Date:** _____

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"YOUR COMFORT IS OUR CONCERN"

Do you have a Do Not Resuscitate (DNR) on file: Yes ___ No ___

During the past month, have you been feeling down, depressed or hopeless? Yes ___ No ___

During the past month, have you been bothered by having little interest in doing things?
Yes ___ No ___

Is this something with which you would like help? Yes ___ Yes, but not today ___ No ___

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way?
Yes ___ No ___

COVID

Do you currently have or had any of these symptoms in the past 4 days?

• Fever	Yes	No
• Cough	Yes	No
• Sneezing	Yes	No
• Sore Throat	Yes	No
• Headache	Yes	No
• Chills	Yes	No
• Muscle Aches	Yes	No
• Extreme Fatigue	Yes	No
• Been in Contact with someone who test Positive for Covid	Yes	No

CANCELLATION POLICY

- Your account will be charged $50.00 if you cancel without 24-hour prior notice
- Patients, NOT, Insurance Companies are responsible for this fee
- Workers Compensation and No Fault patients will have their insurance notified
- After 2 No Show appointments and/or 3 Cancellations without rescheduling, your Physician will be notified of your Non-Compliance

NOTICE OF HIPPA POLICY PRACTICES

A HIPPA NOTICE OF PRIVACY PRACTICES is attached, and by signing here I acknowledge that I have received and/or reviewed it and consent to the use of my information for payment and treatment purposes.

Signature: _____ **Date:** _____

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Registered Physical Therapists

"YOUR COMFORT IS OUR CONCERN"

HIPPA NOTICE OF PRIVACY

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The Privacy Rule provides standards for health care providers to follow when disclosing health information about the patient that is needed to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information. We want to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. You may request restrictions pertaining to parties you do not want PHI released to. You will be asked to authorize release of PHI to any party that is not directly connected to your treatment, payment or health care operations.

If you have any questions, comments or objections to the privacy policies on this form, please ask to speak with our HIPPA Privacy Officer. You have the right to review our entire notice of privacy policies upon request.

Thank you for being one of our highly valued patients.

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