225 Howells Road, Bay Shore, NY 11706
3385 Veterans Memorial Hwy, Ronkonkoma, NY 11779
55 Bryant Ave, Roslyn, NY 11576

Please complete the following forms before being seen by a physical therapist. Answer as completely as possible.

Patient Name: ______________________ Date of Birth: ____________

Marital Status: □ Single □ Married □ Other __________ Social Security #: ____________

Address: ____

____

Cell Phone: ____________ Home Phone: ____________ E-Mail: ______________

Preferred Contact Method: □ Cell Phone □ Home Phone □ E-Mail

Referring Physician: __________________ Primary Physician: ______________

Employer: ________________________ Employer Phone: ______________

Employer Address: ____

____

Human Resource Contact Person: ______________________________

Attorney name: ______________________ Attorney Phone: ______________

History:

What problem brought you to physical therapy? ______________________

How did this problem begin? ______________________________

What tests have you had for this problem? __________________________

What prior treatment have you had for this problem, if any? ______________

Did you have surgery for this problem? □ Yes. □ No. Surgery Date: ______________

Type of surgery ____

What medications are you currently taking (include dosage, over the counter and supplements)? _______

____

Do you use a: (check all that apply)

□ Sling? □ Brace? □ Cane? □ Walker, rolling walker or rollator?

□ Manual wheelchair? □ Motorized wheelchair or scooter? □ Other____________

Do you have a history of the following? (Check all that apply.)

□ Heart condition □ Diabetes □ High Blood Pressure □ Pacemaker/ Defibrillator □ Asthma □ Arthritis

□ Peripheral Vascular Disease □ Dementia □ Coronary Artery Disease □ Chronic Lung Disease

□ Connective Tissue Disease □ Ulcer □ Liver Disease □ Stroke/CVA □ Kidney Disease □ Tumors

□ Back or Neck Pain □ hip/ leg/ knee/ ankle pain □ Shoulder Pain □ Hand/Wrist Pain □ Cancer

□ Metastasis □ AIDS □ Other: ____________________

Please list any allergies you have: ____________________

Present Status:

What is your main symptom or problem? ____________________

____

Are there any positions or activities that make your condition worse? ____________________

Are there any positions or activities that ease your condition? ____________________

Pain:

Where is your primary area of pain? ____________________

Describe the nature of your pain (aching, dull, radiating, sharp, etc.) ____________________

When did the pain begin? ____________________

How frequently do you have the pain?

□ Rarely (less than 10% of the day) □ Occasionally (11-25%) □ Intermittently (26-50%)

□ Frequently (51-75%) □ Constantly (76-100%)

Rate your major area of pain on a scale from 1-10. Circle the number that rates your pain at present.

0 1 2 3 4 5 6 7 8 9 10

Circle the number that rates your worst pain in the past week.

0 1 2 3 4 5 6 7 8 9 10

Personal:

Are you currently employed? □ Yes □ No Are you currently working? □ Yes □ No

Please describe your occupation and physical demands: ____________________

In what leisure activities do you participate? ____________________

Please describe your involvement in this activity: □ Casual/Hobby □ Amateur □ Professional

Do you belong to a club or league? □ Yes □ No. If yes, where? ____________________

What are your personal goals for physical therapy? ____________________

____

Panetta
Physical Therapy & Motion Specialists

ASSESSMENT TESTING SCREENING TOOL

Patient Name: ______________________________ Date: ______________________

Dear patient:

If you currently feel, have felt, or have been diagnosed with any of the following symptoms or conditions, please check the appropriate boxes.

This is a screening tool that can help your Physical Therapist determine what assessment tests* might be appropriate for you.

Please check all that apply:

	Low back pain		Weakness in the arms		Diagnosed with diabetes
	Numbness in the legs		Weakness in the hands		Diagnosed with neuropathy
	Neck pain		Weakness in the legs		Dizziness/ Vertigo
	Numbness in the arms		Overall muscle weakness		Headaches
	Numbness/ tingling in the hands		Loss of sensation or decreased sensation in hands		History of falls due to dizziness or unsteady gait
	Numbness/ tingling in the feet		Loss of sensation or decreased sensation in feet		Hypertension or hypotension
	Burning sensation		Radiating pain in arms		Blurred vision
	Sensation of pins & needles		Radiating pain in legs		Hearing problems

*Electromyography/ Nerve Conduction Studies, Musculoskeletal Ultrasound, Somatosensory Evoked Potentials, Auditory & Visual Evoked Potentials, Vestibular testing.

For office use below this line:

Recommended testing (check all that apply):

	Musculoskeletal ultrasound		EMG / NCV			Other:
	Location:		Upper		Lower	

Panetta
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Patient Agreements

Contact Information Agreement

I, (please PRINT patient name) ____, give permission to Panetta Physical Therapy to use the contact information I have provided to contact me with reminders that I have an appointment for treatment or services at the facility, recommend possible treatment alternatives, and provide notification of other health-related services that may be of interest to me. The Financial Department may also use this information to contact me regarding payment and insurance situations.

____
Patient Signature

Acknowledgement of Notice of Privacy Practices

By signing this form, you acknowledge that you have received the Notice of Privacy Practices for Panetta Physical Therapy, which describes Panetta Physical Therapy's use and disclosure of your individually identifiable health information for treatment, payment, and health care purposes (as described in the notice) in addition to other persons and medical staff providing services at each Panetta Physical Therapy affiliate or other entities carrying out functions necessary for Panetta Physical Therapy to render services to you.

____
Patient Signature

If patient is unable to acknowledge or is a minor, please indicate below.

Patient is a: □ minor □ unable

____
Name of Personal Representative (please print)

____
Signature of Personal Representative

____
Relationship to Patient

Attention Patients:

We require that you get a new prescription **every time you see your MD.** Please also note that some insurance companies (e.g. Workers Comp) require a new prescription **every 30 days.** Medicare requires a new prescription **every 90 days.**

Attention Workers Compensation & No Fault Patients:

Please note that it is your responsibility to inform us if you are scheduled to have an independent medical exam (IME) with a doctor from your insurance company. We appreciate your cooperation in this matter.

Patient Agreements

Patient/Policyholder Verification and Responsibility

Patient's Name: ______________________________

PRIMARY Insurance Carrier: ______________________________

SSN/ID#: ______________________________

It is your responsibility as a policyholder to confirm that the insurance information you are providing our facility with is your primary insurance carrier. If this carrier denies any or all of your medical claims because you are covered under another insurance company, you will be held solely responsible.

I, ______________________________, declare that the insurance information I am providing to Panetta Physical Therapy is my primary insurance carrier and I understand that I will be solely responsible for any unpaid services if the bills are denied for this reason.

______________ ______________________________

Date **Signature of Policyholder**

______________________________ ______________________________

Witness **Signature of Claimant/Guardian (if minor or other than policyholder)**

Direct Assignment Of My Rights and Benefits

Patient's Name: ______________________________

SSN: ______________________________

Claim/Group: ______________________________

I hereby instruct and direct ______________________________ Insurance Company to pay by check made out and mailed to: **Panetta Physical Therapy, 225 Howells Rd., Bay Shore NY 11706.**
If my current policy prohibits direct payment to doctor offices, I agree to endorse the check and forward to the address above.
For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, ANY BALANCES of said professional service charges over and above the insurance payment.

Please be advised that VERIFICATION of coverage is NOT A GUARANTEE of payment. Therefore, regardless of insurance status, you are ultimately responsible for the balance of your account for any professional services rendered.

A photocopy of the assignment shall be considered as effective as the original.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

______________________________ ______________________________

Signature of Patient or Policyholder **Patient Care Coordinator (witness)**

______________________________ ______________________________

Signature or Guardian (if minor) **Today's Date**

Panetta
Physical Therapy & Motion Specialists

Notice of Privacy Practices

How is patient privacy protected?

At Panetta, we understand that information about you and your health is personal, and strive to maintain the confidentiality of your health information. We continuously work to safeguard that information through administrative, physical, and technical means, and otherwise abide by applicable federal and state guidelines.

How do we use and disclose health information?

When you come to Panetta, we use and disclose your health information only for the normal business activities that the law classifies within the categories of treatment, payment, and health care operations. The following are examples of those activities: (Note: Not every use or disclosure falls within the categories listed.)

- Treatment: We keep a record of each visit and/or admission. This record may include your test results, diagnoses, and your response to other therapies or treatments. We disclose this information so physical therapists, physical therapy assistants and aides, other staff members, and other medical offices associated with your care can ensure the optimum plan of treatment and your progression is communicated on a regular basis.
- Payment: We document the services and supplies you receive at each visit so you, your insurance company, or another third party can provide payment to us. We may tell your health plan about upcoming treatment or services that require prior approval by your health plan.
- Health Care Operations: Health information is used to improve the services we provide, to train staff and students, for business management, quality improvement, and for customer service. For example, we may use your health information to review our treatment and services, and to evaluate the performance of our staff in caring for you.

Cases in which we are limited by state law to release certain categories of health information are:

· Complying with federal, state, or local laws that require disclosure · Informing authorities to protect victims of abuse or neglect · Complying with federal and state health oversight activities such as fraud investigations · Responding to law enforcement officials or judicial orders, subpoenas, or other processes · Conducting research following internal review protocols to ensure the balancing of privacy and research needs · Averting a serious threat to health or safety · Assisting in specialized government functions such as national security, intelligence, and protective services · Informing workers' compensation carriers or your employer if you are injured at work · Recommending treatment alternatives · Notifying you of health-related products and services · Communicating with other Panetta organizations for treatment, payment, or health care operations · Communicating with other providers, health plans, or their related entities for their treatment or payment activities, or health care operations activities relating to quality assessment of licensing · Providing information to contractors, agents, and other business associates who need information in order to assist us with obtaining payment or carrying out business operations, such as medical record transcription services. We may also share your health information with an insurance company, a law firm, or a risk management organization in order to obtain professional advice about how to manage risk and legal liability, including insurance or legal claims.

What are Panetta's responsibilities?

By law, Panetta is required to:

- Maintain the privacy of your health information.
- Provide this notice of our duties and privacy practices.
- Abide by terms of the notice currently in effect.

We reserve the right to change privacy practices, and make the new practices effective for all the information we maintain. Revised not will be posted in our facilities and we will offer you a copy when you receive services.

Do I have any federal rights?

The law entitles you to:

- Make a written request to inspect and copy certain portions of your health information.
- Request amendment of your health information if you feel the health information is incorrect or incomplete. (However, under certain circumstances, we may deny your request.)
- Make a written request that we restrict how we use or disclose your health information (However, we are not required to honor your request.)
- Make a written request that we communicate with you at a specific telephone number or address.
- Obtain a paper copy of this notice.

What if I have a complaint?

If you believe that your privacy has been violated, you may file a complaint in writing to:

Panetta Physical Therapy, P.C.
Health Information Management
225 Howells Rd.
Bay Shore, NY 11706

or to:

Secretary of Health and Human Resources
200 Independence Ave. S.E.
Washington, DC 205201

Who will follow this notice?

This notice describes Panetta's practices and those of all departments and divisions of Panetta Physical Therapy which have access to health information. Your personal care providers may have different policies or notices regarding their use and disclosure of your health information created in their offices.

Panetta Physical Therapy
Motion Specialists

Bay Shore NY: 225 Howells Rd. 2nd Floor (P) 631.665.4560 (F) 631.665.7213
Ronkonkoma NY: 3385 Vets Mem Hwy. (P) 631.676.3111 (F) 631.676.3116
Roslyn NY: 55 Bryant Ave, 2nd Floor (P) 516.484.9775 (F) 516.625.7701

No-Show / Same-day Cancellation Policy

At **Panetta Physical Therapy** we expect you to get the most out of your physical therapy visits. Your physical therapist will provide you with your plan for care during the evaluation appointment and will inform you of the required number of visits to help you meet your goals. A recent study has shown that patients who adhere to their physical therapy plan of care increase their ability to have success from physical therapy by 93%.

Even one missed visit can significantly decrease your success and result in a more chronic problem. We strongly stress the importance of keeping all scheduled appointments to achieve your personal physical therapy goals.

Our schedule is very full and certain time slots are not always available for patients who need them. For this reason, we expect at least 1 days' notice if you cannot attend an appointment; for any reason. If you cannot make a scheduled appointment, for any reason, we require a day's notice of the cancellation. When you call we will assist you in rescheduling this appointment because getting you results is our main goal.

Please read the following policy and sign at the bottom indicating you understand our same-day cancellation / no-show policy and agree to adhere to the expectations listed below.

1. As experts, we know that you will not get better if you do not attend your appointment. When you call to cancel an appointment, we expect that you will have other times available so we can reschedule you right away.
2. We require that you cancel any appointment that you cannot make with no less than 24 hours' notice.
3. We will reschedule you at that time to make sure you continue with your plan of care.
4. While we understand that illness can strike at anytime, repeated cancellations for illness without 24 hours' notice will not be an accepted excuse for untimely notice.
5. For all appointments, we expect that you will arrive on time, dressed for your session, and ready to begin at your scheduled treatment time.
6. While traffic can be unpredictable, we expect that you will call us immediately if you are running late for your scheduled appointment, so we can be prepared for your late arrival.
7. Please also be aware that if you are late for your appointment, you are missing the time that we have specifically scheduled for your care and we cannot guarantee that we will be able to provide you with your full treatment as we have reserved the appointment time following yours for someone else. Chronically late patients will be asked to change their appointment times.
8. **Please note, you will be charged a $50 fee for any no-shows and ALL cancellations that occur with less than 24 hours' notice. This amount is your responsibility as insurance will not cover this fee.** To avoid the $50 fee, you simply need to call the office and provide at least 24 hours' notice for any appointments you cannot attend. Calls the night before your appointment will not count as timely notice so please call during business hours.

Thank you for reviewing this policy. Please sign and return the signed copy and keep the second copy for your records.
We look forward to working with you to meet your physical therapy goals.

Christina Panetta, PT,

I have read this policy and by signing below I am indicating that I understand and will adhere to this policy.

______________________________	______________________________	______________
Patient Signature	Patient Name	Date