EAST END PHYSICAL THERAPY

PATIENT HISTORY FORM

Name:(Last)_____(First)_____ Weight: _____ Height: _____

Social Security Number: _____ Date of Birth: _____

Mailing Address: _____ Home Phone: _____

(City)_____(State)_____ Cell Phone:_____

(Zip)_____ Email: _____

Emergency Contact Name: _____ Number: _____

Primary Care Doctor: _____

Gender: M / F

Pacemaker: Yes / No

Smoker: Yes / No

Pregnant: Yes / No

Occupation:

Past Surgeries (list & date): _____

_____

Current Medications (prescription, over-the-counter): _____

_____

_____

Past Medical History: Have you ever been told you have any of the following?

Cancer	Yes	No	Blood Clots	Yes	No
Heart Problems	Yes	No	Infectious diseases	Yes	No
High Blood Pressure	Yes	No	Lung Problems	Yes	No
Angina/Chest Pain	Yes	No	Hepatitis	Yes	No
Asthma	Yes	No	Anemia	Yes	No
Diabetes	Yes	No	Allergies	Yes	No
Osteoporosis/Osteopenia	Yes	No	Fibromyalgia	Yes	No
Thyroid problems	Yes	No	Kidney disease	Yes	No
Rheumatoid arthritis	Yes	No	Stroke	Yes	No
Osteoarthritis	Yes	No	Seizures/Epilepsy	Yes	No
Depression	Yes	No	Others _____		

Currently: Are you experiencing any of the following? (circle all that apply):

Fever/chills/sweats	Poor balance (falls)	Unexplained weight loss	
Numbness/tingling	Changes in appetite	Difficulty swallowing	Pelvic pain
Depression	Shortness of breath	Night pain	Headaches
Dizziness	Nausea/vomiting	Changes in bowel or bladder functions	

Therapist Signature: _____ Date: _____

Name: _____ Date: _____

Current History:

On the scale below, circle the number which best represents the average level of pain you have experienced over the last 48 hours:

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst pain Imaginable

What date (approximately) did your present symptoms start? _____

How? (gradually, suddenly, injury) _____

How have your symptoms changed? Getting better about the same getting worse

What makes your symptoms better? _____

What makes your symptoms worse? _____

Have you had an x-ray, MRI, or other testing for this problem? No / Yes (specify) _____

What treatments have you received for this problem so far? _____

How did you hear about us? _____

Electrical Stimulation Pad Policy

Electrical stimulation therapy is a treatment modality that your referring physician or treating therapist may deem appropriate for optimal treatment of your condition.

For sanitary reasons, company policy requires that all patients receiving electrical stimulation therapy be provided a personal set of electrical stimulation pads at a cost of five dollars **($5.00 per set of "personal pads")**. The personal pads will be utilized solely by the individual and will not be utilized by any other patient.

Manual + Sports PT Southampton
167 S Main Street
Southampton NY 11968
(631) 283 - 4190

East End Physical Therapy
300 Pantigo Place - Suite 112
East Hampton NY 11937
(631) 329 - 1828

Manual + Sports PT Sag Harbor
60A Bay Street
Sag Harbor NY 11963
(631) 725-4450

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Assignment of Benefits

I have coverage with the above insurance company, and assign directly to Manual & Sports Physical Therapy all medical benefits. I authorize Manual & Sports Physical Therapy to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions.

Per New York state law, I understand it is my responsibility to provide an up to date prescription from my referring physician. I will not be seen for physical therapy with an out of date prescription.

I have read the notice of privacy practice (separate sheet) and am informed of my rights and the practices and legal duties with regard to my protected health information.

Cancellation Policy

Our policy requires that patients give 24-hour notice for all appointment cancellations. This policy is in place to maximize your progress and minimize loss of appointment availability for other patients. Cancellations with less than 24-hour notice and no shows for scheduled appointments will be subjected and billed a fee for $40.00 for each missed appointment. This is not covered by your insurance company.

Medicare Therapy Cap

The Medicare annual dollar limit and targeted medical review threshold for Physical and Speech Therapy combined for 2020 is $3000. That is approximately 25 visits per calendar year. Medicare pays 80% of each visit. Some secondary insurance will pay the remaining 20%. You may have a co pay with your secondary insurance; we will inform you if you do. If you have had physical therapy in another location prior coming to East End Physical Therapy please let us know so we can check what your available balance with Medicare is.

Print Name: _____ Date: _____

Patient/Guardian Signature: _____