5700 W. Genesee St.
Suite 2S
Camillus, NY 13031
P: 315-468-1050
F: 315-468-1201

601 South Main St.
North Syracuse,
NY 13212
P: 315-452-5580
F: 315-452-5303

Patient Information Form

Last	First	M.I.	Date Of Birth:	Sex: ☐M ☐F
Address:	City:	State:	Zip:	
S.S.N.:	Home Phone:	Cell Phone:	Work Phone:	
Employer / Occupation:	Employer Address:			
If Patient is a minor, Name of Parent / guardian:	Relationship:			

Primary Insurance Information

Name of Insurance Subscriber	Sex: ☐M ☐F	S.S.N.:
Address (if different from above)		
Subscriber's Date of birth	Relationship to patient: ☐ Self ☐ Spouse ☐ Parent/Guardian	
Insurance co.	ID#:	Group #:
Insurance co. Address:		
Subscriber's Employer:	Employer's Address:	

Secondary Insurance Information

Name of Insurance Subscriber	Sex: ☐M ☐F	S.S.N.:
Address (if different from above)		
Subscriber's Date of birth	Relationship to patient: ☐ Self ☐ Spouse ☐ Parent/Guardian	
Insurance co.	ID#:	Group #:
Insurance co. Address:		
Subscriber's Employer:	Employer's Address:	

Referring Doctor: ______________________________

Primary Care Physician: ______________________________

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CNY Physical Therapy and Aquatics

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Name: ______________________ Date: ______________

Gender: ☐M ☐F **Are you currently pregnant?** ☐Y ☐N **Do you currently exercise at least 3 days a week?** ☐Y ☐N
Do you smoke? ☐Y ☐N **Age:** ________
What is the problem that brings you to PT? ______________________

Current Medications (do not list over the counter medications): ______________________

Please check any condition you have, or have had.

____ Cancer
____ High blood pressure
____ Osteoporosis
____ Allergies/Asthma
____ Diabetes Mellitus
____ Osteoarthritis
____ Lung Disease
____ Kidney Disease
____ Angina/Chest pain
____ Rheumatoid Arthritis
____ Ulcers
____ Sexually Transmitted Disease
____ Heart Attack (if yes, when?__________)
____ Stroke (If yes, when? __________)
____ Fibromyalgia
____ Recent Illness (explain __________ __________)

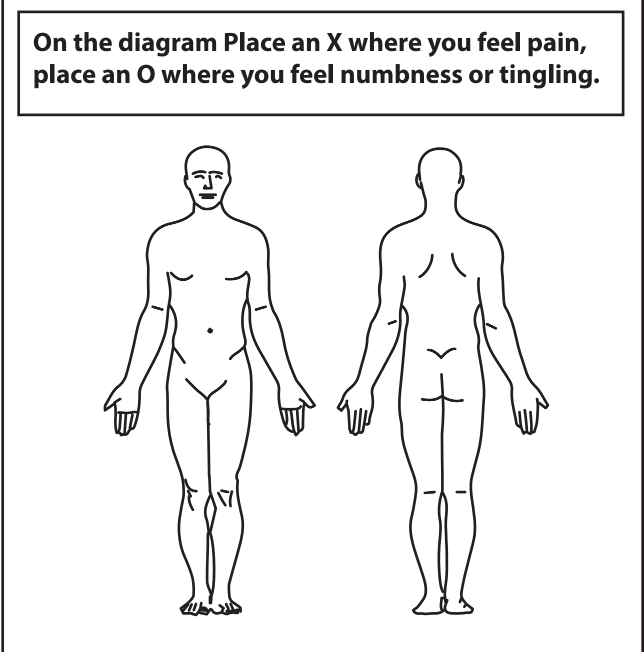
Do you have an allergy to latex? ☐Y ☐N
Do you take blood thinners? ☐Y ☐N

Please check any condition you are currently experiencing.

____ Unexplainable weight loss
____ Depression
____ Headaches
____ Change in bowel/bladder function
____ Numbness/tingling
____ Shortness of breath
____ Pain at night
____ Change in Appetite
____ Dizziness
____ Nausea/Vomiting
____ Poor balance
____ Difficulty Swallowing
____ Fever/chills/sweats

How do you sleep at night? ____ No difficulty ____ Moderate Difficulty ____ Only with medication.
During the past month have you been bothered by feelings of depression or hopelessness ☐Y ☐N
During the past month have you lost pleasure or interest in your recreational activities? ☐Y ☐N

On the diagram Place an X where you feel pain, place an O where you feel numbness or tingling.



On the scale below, indicate the number that best represents your overall level of function.

0 1 2 3 4 5 6 7 8 9 10

Cannot do anything <---> no difficulty

On he scale below, indicate the number that 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

Have you received health care this year? (I.e. blood draws /nursing/physical therapy)

☐Y ☐N If so, date you were discharged? __________

Have you had any physical therapy elsewhere this year?

☐Y ☐N If so, where and when were you were discharged?

____

How did you hear about CNY Physical Therapy? __________Newspaper __________Online __________Doctor __________other

In case of emergency, who should we contact? ______________________

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CNY Physical Therapy Office & Financial Policies

- **Making or changing appointments:**
  Appointments are made weekly at the front desk. There are no "standing appointments". You will be given a printout of your scheduled appointments. We suggest that you do not discard this printout in the event of a scheduling error.

- **Cancellation Policy:**
  If you need to cancel an appointment, please call our office within 24 hours and reschedule your appointment. Three consecutive cancellations are grounds for a discharge.

- **No-Show Policy:**
  If you fail to make your scheduled appointment and do not contact our office you will be charged a $25.00 fee. This fee must be paid before scheduling further appointments, and we reserve the right to discharge you if you no-show more than once.

Our relationship is with you, not your insurance company. It is your responsibility to contact your insurance to determine if you have a co-pay, and what your physical therapy coverage is.

We will be happy to submit claims on your behalf to your insurance company; however, it is your responsibility on your first visit to provide us with accurate insurance info. (I.e. Worker comp, no-fault or private insurance.) If you realize during your course of therapy that you provided us with the wrong insurance information, it is your responsibility to pay for treatments rendered. We will not re-bill another carrier for you.

Co-pays are due at time of service. If we must bill you for your co-pays, a $5.00 processing fee will be added to each date of service. You may wish to make co-pays at the end of the week. We accept cash, check, or credit cards.

You will receive a billing statement for any unpaid balances, co-insurance or charges determined not covered under your policy. A $5.00 billing fee will be applied to all accounts over 30 days. Any disputes with balances must be brought within 30 days of the 1st billing, or they will not be considered.
NOTE: some insurance companies take 30-60 days to process our claims; therefore a billing charge would only be applied if you fail to remit payment within 30 days of your second statement from us.

We understand that temporary financial problems do arise and we encourage you to contact our Billing Manager promptly for assistance in the management of your account. Special payment consideration may be extended in the event of unusual circumstances.

- **By signing below you are also acknowledge that you were offered a copy of the CNY Physical Therapy Notice of Privacy practices.**

Assignment of benefits:

I authorize the release of any medical information necessary to process my insurance claim(s). I authorize and request payment of medical benefits directly to CNY Physical Therapy. I agree this authorization will cover all medical services rendered until such authorization is revoked by me.
I understand and agree that regardless of my insurance status, I m ultimately responsible for any balance on my account for any professional services rendered. I will notify CNY Physical Therapy of any changes in my address, phone number or my insurance status. In the event that my account is assigned for collection, I agree to pay an additional collection fee of $15.00 as well as any associated attorney fees.

Signature:	Print Name:	Date:

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INFORMED CONSENT FOR PHYSICAL THERAPY

Dear Patient:

Physical therapy involves the use of many different types of physical evaluation and treatment. As with all forms of treatment, there are benefits and risks involved with physical therapy.

The physical response to a specific treatment can vary widely from person to person. We are not always able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help the condition for which you are seeking treatment. There is also a risk that your treatment may cause pain, or aggravate previously existing conditions.

You have the right to ask your physical therapist what type of treatment he of she is planning based on your history, diagnosis, symptoms, and testing results. You may also discuss with your therapist what the potential risks and benefits of treatment are. You have the right to decline any portion of your treatment at any time before or during your treatment session.

I acknowledge that my treatment program has been explained by my therapist, and all of my questions have been answered to my satisfaction. I understand the risks associated with a program of physical therapy as outlined to me, and I wish to proceed.

____

Patient Name **Patient Signature** **Date**