NIAGARA PHYSICAL THERAPY

Current Condition

Name: _____ **Date:** _____

Signature: _____

When did the injury or illness start? __ __ / __ __ / __ __ __ __
Month Day Year

What was the **cause** of your current condition: _____

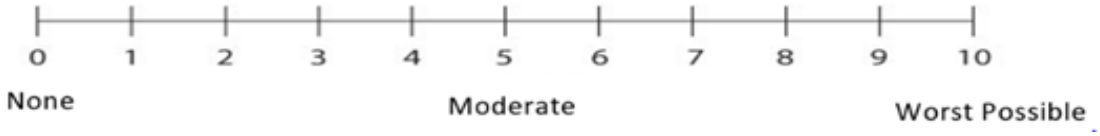
_____

Please **describe** your current symptoms: _____

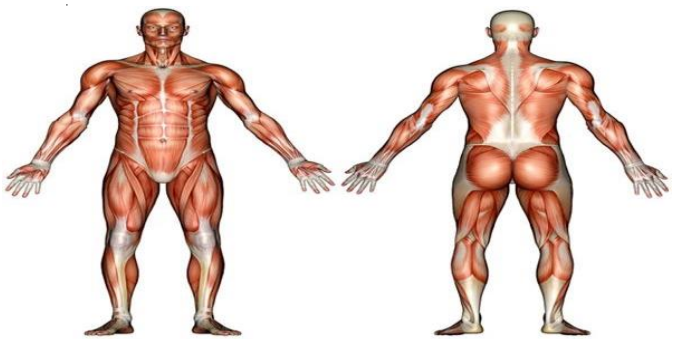
_____

According to the scale below, rate the level of your symptoms.

Worst: _____
Current: _____
Best: _____



Please mark where you are experiencing your symptoms:



Better With: (check all that apply)

- ☐ Sitting
- ☐ Bending Forward
- ☐ Sit to Stand
- ☐ Lying on Side
- ☐ Morning
- ☐ Rest
- ☐ Stairs
- ☐ Pain Medicine
- ☐ Standing
- ☐ Bending Backward
- ☐ Walking
- ☐ Lying Flat
- ☐ Evening
- ☐ Movement
- ☐ Stretching
- ☐ Heat/Ice

Worse With: (check all that apply)

- ☐ Sitting
- ☐ Bending Forward
- ☐ Sit to Stand
- ☐ Lying on Side
- ☐ Morning
- ☐ Rest
- ☐ Stairs
- ☐ Pain Medicine
- ☐ Standing
- ☐ Bending Backward
- ☐ Walking
- ☐ Lying Flat
- ☐ Evening
- ☐ Movement
- ☐ Stretching
- ☐ Heat/Ice

Please list any other activities or movements that you are limited with: _____

_____

What do you want to work on in Physical Therapy and what goals do you have: _____

_____

NIAGARA PHYSICAL THERAPY

Patient Information

Name: _____ Date of Birth: _____ Age: _____

Referring Physician (If Any): _____

Next appointment with Referring Physician: _____

How did you hear about our office? _____

Is there anyone we can thank for your referral other than your doctor? _____

Medical History

Have you experienced this condition in the past? ☐ Yes ☐ No If Yes, When? _____

Are you receiving or have you received any other treatments for your current condition? Home PT/OT, Outpatient PT/OT, Chiropractic, Massage, Injections, Other _____

If Yes, what type and when? _____

Have you had any related surgeries? ☐ Yes ☐ No

If Yes, what type and when? _____

Please check if you currently have or ever had any of the following:

☐ Arthritis	☐ Osteoporosis	☐ Broken Bones/ Fractures	☐ Skin Diseases
☐ High Blood Sugar	☐ Low Blood Sugar	☐ Diabetes	☐ Infectious Disease
☐ Seizures	☐ Epilepsy	☐ Depression	☐ Thyroid Problems
☐ High Blood Pressure	☐ Stroke	☐ Circulation	☐ Kidney Problems
☐ Parkinson's Disease	☐ Muscular Dystrophy	☐ Multiple Sclerosis	☐ Blood Disorders
☐ Head Injury	☐ Allergies	☐ Ulcers/Stomach Problems	☐ Lung Problems
☐ Cancer	☐ Heart Problems	☐ Pacemaker/Defibrillator	☐ Asthma

Please describe any of the above checked boxes: (types, dates, etc.)

_____

_____

Medication List: (Please include over the counter medications and/or supplements. You may provide a list for our office to copy.)

Drug	Dosage	How often	Reason

☐ Check here if you gave a separate list of medication

**Please inform your therapist of any medication changes that may occur throughout the course of your treatment.

_____ _____

Signature Date

NIAGARA PHYSICAL THERAPY

Patient Authorization for Release of Medical Records

Patient's Name:_____ **DOB:**_____

Address: _____

_____

☐ I give my authorization to release the above protected information to **NIAGARA PHYISCAL THERAPY**

☐ I also authorize **NIAGARA PHYSICAL THERAPY** to **release** any of the above protected information, and/or to speak to the following **person or organization**, (other than referring/primary doctor(s) when needed

Name: _____

Relationship to Patient: _____

Phone: _____

Please check all information that applies:

☐ Chart notes
☐ MRI reports
☐ X-rays
☐ CAT scan
☐ Other (please specify):
☐ All of the above

Please indicate which body part and/or side: _____

This authorization will end **Eight (8) years** from the date below:

Signature of patient: _____ Date: _____

NIAGARA PHYSICAL THERAPY

CANCELLATION POLICY

Our goal is to provide quality health care to all our patients in a timely manner. No-shows, late arrivals, and cancellations inconvenience not only our providers, but our other patients as well. Please be aware of our policy regarding missed appointments.

Appointment Cancellation:
When you book your appointment, you are holding a space on our calendar that is no longer available to our other patients. In order to be respectful of your fellow patients, please call our office as soon as you know you will not be able to make your appointment.

If cancellation is necessary, we require that you call at least 24 hours in advance. Appointments are in high demand, and your advanced notice will allow another patient access to that appointment time.

How to Cancel Your Appointment:
If you need to cancel your appointment, please call us at (716)-754-7220. If necessary, you may leave a detailed voicemail message. We will return your call as soon as possible.

Late Cancellations/No-Shows:
A cancellation is considered late when the appointment is canceled less than 24 hours before the appointed time. A no-show is when a patient misses an appointment without canceling. In either case, we will charge the patient a $40 missed appointment fee. This fee can be avoided if the patient reschedules within a 24 hour period from their original appointment time.

If a patient no-shows for 2 appointments or cancels 3 appointments, you may be discharged from our care and a case update will be sent to the referring doctor.

I have been informed of this cancellation policy and agree to its terms and conditions.

PATIENT NAME (PRINT): _____

PATIENT SIGNATURE: _____ **DATE:** _____

STAFF SIGNATURE: _____ **DATE:** _____

NIAGARA PHYSICAL THERAPY

INSURANCE AGREEMENT

ASSIGNMENT AND RELEASE:

I hereby authorize Niagara Physical Therapy to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I have insurance coverage and assign all insurance benefits, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges not covered by insurance(s).**

Primary Insurance: _____

Plan runs: _____

Visits allowed: _____

$ _____ Copay _____ % Coinsurance

$ _____ Deductible $ _____ has been met

$ _____ OOP $ _____ has been met

Additional Information: _____

Secondary Insurance: _____

Plan runs: _____

Visits allowed: _____

$ _____ Copay _____ % Coinsurance

$ _____ Deductible $ _____ has been met

$ _____ OOP $ _____ has been met

Additional Information: _____

**** Have there been any changes to your insurance coverage for 2026? ☐Yes ☐No** _____

(i.e.- new plan/company, copay amount, deductible, etc) **INITIAL HERE**

Changes to your insurance plan could affect your coverage. Please notify us immediately of any changes. You are responsible for co-pays, co-insurances and deductibles, and any other provisions stated in your plan. If you have any questions regarding your coverage, please contact your insurance carrier.

I have been informed of my insurance details and agree to its terms and conditions.

PATIENT SIGNATURE: _____ **DATE:** _____

PATIENT NAME (PRINT): _____

STAFF SIGNATURE: _____ **DATE:** _____