2099 GRAND ISLAND BLVD.
Suite B
(716) 773-3300

Patient Information Form

Name: First: _____ MI: _____ Last: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Sex: Male Female E-mail Address: _____

Emergency Contact/Phone #: _____

Referring Physician: _____

Date of Injury: _____

DO YOU HAVE AN OPEN WORKMAN'S COMP OR NO-FAULT CASE FOR THIS BODY PART? Y N

PRIMARY INSURANCE INFORMATION

Insurance Company Name: _____

ID #: _____ Group #: _____

Name of Person Insured: _____ Relation: _____

Insured's Employer: _____ Insured Person's Date of Birth: _____

Describe in a ***FEW SHORT*** sentences your main reason for this appointment:

_____

_____

_____

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Medical History Form

Name: _____ **Age:** _____

Please indicate if you have had or now have the following:

Condition	Y	N	Condition	Y	N
High blood pressure			Abdominal or Mid-Back Pain		
Heart disease/attack, pacemaker			Open wounds		
Cancer			Skin condition		
Osteoarthritis			Metal implant/fragments		
Rheumatoid arthritis			Osteoporosis		
Diabetes			Vascular problems		
Fracture			Neck or back problems		
Stroke or TIA			Fever and chills		
Infectious disease			Unexplained weight loss		
Seizures/Epilepsy			Pregnant now		
COPD, bronchitis, asthma					
Joint Replacements					

If you marked yes above, please provide more information:

_____

_____

Please list all previous surgeries:

_____

_____

Please list all medications currently being taken (include all over the counter and herbal supplements):

_____

_____

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Pain Assessment Chart

Name: _____ Today's Date: _____

Age: _____ Occupation: _____

1. Where is your pain?

   _____

2. When did it start?

   _____

3. Is your pain the result of an injury?

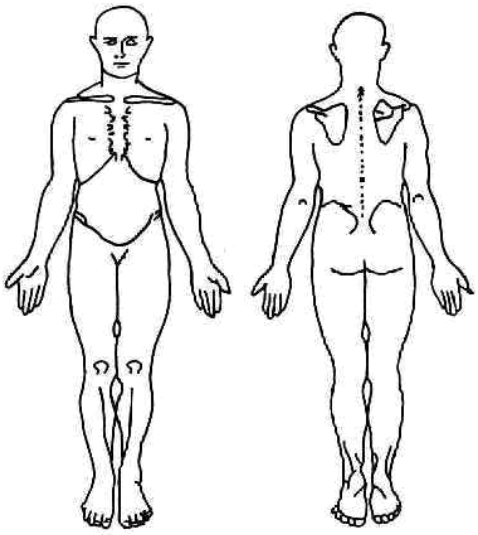
   _____

4. Is your pain constant or intermittent?

5. Describe your pain:

Sharp Dull Achy Deep Burning Throbbing

Please draw pain on the body chart below:



6. Rank your pain from a scale of 1 to 10 (10 is unbearable):

At rest: _____ During activities: _____

7. Is there anything that makes your pain better?

   _____

8. Is there anything that makes your pain worse?

   _____

9. What tests have you had recently?

MRI CT Scan X-Ray EMG

10. What activities do you have difficulties with?

Standing Sitting Walking Stairs Lying down

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Patient authorization for use and disclosure of protected health information and statement of privacy notice.

We may disclose your health care information:

1. To other health care professionals within our practice for the purpose of treatment, payment, or health care operations.
2. To your insurance provider for the purpose of payment or health care operations.
3. To comply with State Workers' Compensation laws.
4. To public health employees for preventing/controlling disease and reporting infectious exposures.
5. In the course of any administrative or judicial proceeding or law enforcement purposes.

Under the HIPPA federal privacy law, you have the right to:

1. Request restrictions on certain uses and disclosures of your health information.
2. Inspect and copy your health care information.
3. Receive an accounting or disclosures of your protected health information made by us.
4. Have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future.

We are required by law to maintain the privacy of your health information.

My signature indicates my authorization and consent for The P.T. Center to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described above.

_____

Patient's Name (please print)

1. _____

Patient's Signature **Date**

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Cancellation Requirements

24 hours' notice for cancellations is greatly appreciated.
Our cancellation policy is as follows:

A NO-SHOW* OR SAME DAY CANCELLATION will result in a **$10.00 cancellation fee. There will be no exceptions.**

If we can reschedule that visit for another day in the same week, the $10.00 fee will be waived.

***3 same day no-show appointments may result in a $30.00 charge and being discharged for non-compliance.**

By signing below, you accept these cancellation terms.

Sign_____Date _____

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Please only complete this portion if you have a Workman's Comp or No-Fault Case

If your Workman's Comp or No Fault case is ***denied***, we will try to bill your secondary insurance. However, if they also deny your case, **you will be financially responsible for any denied visits.**

WORKMAN'S COMP PATIENTS: It is your responsibility to call your doctor and request that they **submit a new MG-2 form to the Workman's Comp Board every 6 WEEKS**. If this is not done, we cannot guarantee that WC will cover your case and you could end up having to pay for these visits.

I understand and accept these terms:

_____	_____	_____
Patient Name	Patient Signature	Date