HARBOR PHYSICAL THERAPY, PC

Patient Information

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work Phone: _____

Email Address: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Sex: M F

Occupation: _____ Employer: _____

Referring Physician Name: _____ Phone: _____

Primary Care Physician Name: _____ Phone: _____

Emergency Contact

Name: _____ Relationship to Patient: _____

Home Phone: _____ Cell: _____ Work Phone: _____

Parent/Guardian Information for Minors

1. Name: _____ Relationship to Patient: _____

   Home Phone: _____ Cell: _____ Work Phone: _____

2. Name: _____ Relationship to Patient: _____

   Home Phone: _____ Cell: _____ Work Phone: _____

How did you hear about Harbor Physical Therapy?

☐ Insurance Company ☐ Internet/Google ☐ Previous Patient ☐ Advertisement

☐ Physician: _____ ☐ Other Person: _____

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Insurance Information

Primary Insurance Company Name:_____

Member's Name:_____ Member's DOB:_____

ID#_____ Group ID#_____ Relationship:_____

Insurance Company Address:_____

Employer:_____ Employer Phone#_____

Secondary Insurance Company Name:_____

Member's Name:_____ Member's DOB:_____

ID#_____ Group ID#_____ Relationship:_____

Insurance Company Address:_____

Employer:_____ Employer Phone#_____

Guarantor Information

Guarantor Name:_____ DOB:_____ Phone:_____

Address:_____

Harbor Physical Therapy, PC will contact your insurance company to verify your physical therapy benefits. We will provide you with the summary of benefits as provided by your insurance company. Verification of benefits is NOT a guarantee of payment. Payment is determined by your insurance company at the time a claim is received. If your insurance coverage changes, you are responsible to inform Harbor Physical Therapy, PC of these changes before or as soon as possible after the new insurance becomes effective. It is your responsibility to fully understand your insurance benefits.

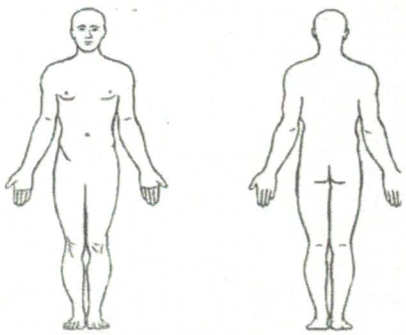
Print Name Signature Date

HARBOR PHYSICAL THERAPY, PC

Please fill out to the best of your ability. These details will help your therapist with the evaluation.

Pain:

1. Please mark on the picture to the right where you have pain or other symptoms.
2. Please describe your pain (Circle those that apply):
   - Localized or Radiating
   - Constant / Frequent / Intermittent
   - Sharp / Dull / Burning / Electrical /Throbbing
   - Deep / Superficial
   - Other:_____



3. Please rate your pain on the following scale: (No pain = 0)

(Lowest) 0 1 2 3 4 5 6 7 8 9 10 (Highest)

Symptoms:

1. Date of injury/ onset of symptoms: _____
2. Cause of injury: ☐ Car Accident ☐ Work-related ☐ Sport ☐Unknown ☐ Other:_____
3. Please describe your injury/symptoms: _____
   _____
4. Since the onset, are your symptoms: ☐ Getting better ☐ The same ☐ Getting worse
5. Previous history of current problem: ☐ Yes ☐ No ☐ Unsure
6. Previous treatment for current problem (if applicable): _____
   _____

Past/Current Medical History:

☐ No significant past medical history

☐ Cardiac arrhythmia	☐ Depression	☐ MS	☐ Pregnant (Currently)
☐ Asthma	☐ Diabetes	☐ Mitral Valve Prolapse	
☐ Cancer	☐ Fractures	☐ Osteoporosis	☐ Rheumatoid Arthritis
☐ Congestive Heart Failure	☐ Heart Attack	☐Osteoarthritis	☐Vascular Disease
☐ COPD	☐ Hypertension	☐ Pacemaker	

☐ Other: _____

☐ Other: _____

History of Falls: ☐ No History ☐ Yes – If yes, how many in the past year? _____

History of: ☐ Alcohol ☐Substance Abuse ☐ Smoking: Packs/day:_____ ☐ Other:_____

Past/Current Surgical History:

☐ No Significant History

☐ Ankle Surgery	Left / Right	☐ Total Hip Replacement	Left / Right	☐ Cardiac Bypass	
☐ Elbow Surgery	Left / Right	☐ Total Knee Replacement	Left / Right	☐ Cancer Surgery	
☐ Hand Surgery	Left / Right	☐ Shoulder Replacement	Left / Right	☐ Pacemaker Placement	
☐ Knee Surgery	Left / Right	☐ Shoulder Surgery	Left / Right	☐ Spine Surgery	

☐ Other (Please Specify):_____

Allergies:

☐ No known allergies
☐ Latex ☐ Seasonal/Environmental ☐ Medications (Please List):_____
☐ Other (Please List):_____

_____ _____
Patient/Guardian Signature Date

For Medicare Patients Only

Height and Weight

Height (inches): _____ Weight (pounds): _____

Medications

Medication	Dosage (Amount taken)	Frequency (How often is it taken)	Administration Route (How is it taken)

HARBOR PHYSICAL THERAPY, PC

Patient Name: _____

Consent for Care and Treatment:
I agree and give my consent for Harbor Physical Therapy, PC to furnish physical therapy care and treatment considered necessary to treat my physical condition.

Patient/Guardian: _____ Date: _____

Medical Records and Information Release:
I authorize Harbor Physical Therapy, PC to release and obtain patient health care information, for the purposes of treatment or payment, to and from my physician, insurance company, attorney, adjustor, or other health care organization pertinent to my care.

Patient/Guardian: _____ Date: _____

Benefit Assignment and Acknowledgment of Financial Responsibility:
I authorize direct payment of all medical claims to Harbor Physical Therapy, PC. for services rendered. If payment for care from my insurance provider is made to me, I agree to remit such payments in full to Harbor Physical Therapy, PC within ten (10) days after my receipt.

I agree to pay Harbor Physical Therapy, PC all amounts that are due for services rendered which are not otherwise paid for by my insurance plan on my behalf within 30 days of the date of service. This includes any deductible, copayment, coinsurance, and any service which is not covered by my insurance plan. In the event that my account is referred to a collection agency or attorney, for non-payment, I further agree to pay all reasonable costs incurred to collect any amounts that are due for services rendered including, without limitation, reasonable attorney's fees.

Patient/Guardian: _____ Date: _____

Consent to Receive Appointment Reminders
I agree and give my consent for Harbor Physical Therapy, PC to send me appointment reminders via text message and/or email. I will provide a working and monitored mobile phone number and/or email account by which I can receive such reminders.

Patient/Guardian: _____ Date: _____

Notice of Privacy Practices
I have been given the opportunity to review the Notice of Privacy Practices of Harbor Physical Therapy, PC.

Patient/Guardian: _____ Date: _____

HARBOR
PHYSICAL THERAPY, PC

Cancellation & No Show Policy

Harbor Physical Therapy understands that situations arise in which you must cancel your appointment. It is therefore requested that, if you must **CANCEL** your appointment, you provide at least 24 hours' notice. This will allow enough time for another patient to be scheduled at your appointment time.

If you do not show up for your appointment, by the scheduled time, without properly canceling the appointment, it will be considered as **NO SHOW.**

IF YOU CANCEL AN APPOINTMENT WITH LESS THAN 24 HOURS' NOTICE OR NO SHOW:

1st Time: A warning and you must provide a mobile phone number to be enrolled in automatic text message reminders for future appointments.

2nd Time: $25.00 fee and you will continue to receive automatic text message reminders for future appointments.

3rd Time: $50.00 fee for this and future violations and you will not be able to schedule appointments in advance (only same day appointments) unless a credit card is left on file with permission to charge the card for all future cancellations or no shows. Scheduling appointments in advanced may be revoked if further violations occur, even if a credit card is left on file. ***If there are no further violations for 30 consecutive days, appointments can once again be scheduled in advance.***

We understand that special or unavoidable circumstances (emergencies) may cause you to cancel your appointment within 24 hours or not allow you to show up for your appointment. In these instances, fees may be waived but only with management approval.

Should you have any questions regarding this policy, please call to speak with the office manager or physical therapist at (631) 425-1110.

Please sign that you have read, understand, and agree to the Cancellation & No Show Policy.

Patient Name (Please Print)	Patient Signature	Date

21 Southdown Road Huntington, NY 11743 • (P)631-425-1110 • (F)631-425-1115 • Office@HarborPhysicalTherapy.com