Staten Island Center For Alternative Therapies

520 Bloomingdale Rd., Staten Island, NY 10309 | Ph: (718) 605-1300

Case History

Name _____ Soc. Sec. # _____ Date _____

Age _____ Date of Birth_____ Sex _____ Marital Status _____

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

E-Mail Address _____

Employer _____ Occupation _____

Emergency Contact: Name _____ Relation _____ Phone # _____

Physician's Name _____ Physician's Phone # _____

Who referred you to our facility? _____

What is your major complaint? _____

How long have you had this condition? _____

What aggravates your condition? _____

Is your condition getting worse? Yes □ No □ Constant □ Comes and Goes □

Is this condition interfering with your: Work □ Sleep □ Daily Routine □ Other_____

Have you sought treatment from other healthcare providers? Yes □ No □

If yes, whom? _____

Length of time under care? _____

Did treatment relieve symptoms? Yes □ No □ Other _____

Did you injure yourself at work? Yes □ No □

Were you involved in an automobile accident? Yes □ No □

If yes, date of injury or accident: _____

Brief description of injury or accident_____

_____

Have you had any other personal injuries or accidents? Yes □ No □

If yes, describe _____

_____

Do you have an attorney? Yes □ No □

Name _____
Address _____
_____
Phone #_____

PATIENT MEDICAL HISTORY

Name: _____ ID#_____ DOB: _____

To help us better evaluate your condition please complete this form to the best of your knowledge.
If you have any questions please ask for assistance. Thank you.

1. If you have Medicare, is a Home Health Agency or Visiting Nursing Association currently seeing you? Yes No

2. Have you received any physical or occupational therapy this year? Yes No

3. If yes, where and when was this service provided? _____

4. In your own words, what is the problem that has brought you here for therapy? _____

_____

5. What would you say is the pain rating for your current condition using a scale of 0 – 10?

(0=no pain, 10=worst pain imaginable) _____ Height _____ Weight _____

SYMPTOMS: In regards to your current condition:

Do you have any "pins and needles" or numbness in your extremities?	Yes	No
Do you have any weakness in your arms or legs?	Yes	No
Do you have any coordination or balance problems?	Yes	No
Do you have difficulty walking?	Yes	No
Do you experience dizziness or vertigo with a change in position?	Yes	No
Have you experienced headaches as a result of your condition?	Yes	No
Have you had this problem before?	Yes	No

6. Have you seen anyone else for your current problem?
( ) Physician/MD ( ) Chiropractor ( ) Podiatrist ( ) Orthopedic Surgeon ( ) Dentist ( ) Osteopath/DO
( ) Neurologist/Neurosurgeon ( ) Physical Therapist ( ) Other: _____ Date: _____

7. Do you have a past or present medical history of the following? **(Please check any condition you have a history of. Items not checked are understood to be negative.)**

__ Allergies	__ Depression	__ Multiple Sclerosis
__ Anemia	__ Diabetes ____ Shoe size	__ Osteoporosis
__ Anxiety	__ Dizziness/Vertigo	__ Parkinson
__ Arthritis	__ Emphysema/Bronchitis	__ Rheumatoid Arthritis
__ Asthma	__ Fractures	__ Seizures/ Epilepsy
__ Cancer	__ Gallbladder Problems	__ Smoke
__ Cardiac Condition	__ Hepatitis	__ Speech Problems
__ Cardiac Pacemaker	__ High/Low Blood Pressure	__ Strokes
__ Cholesterol	__ Incontinence	__ Thyroid Disease
__ Circulation Problems	__ Kidney Problems	__ Tuberculosis
__ Currently Pregnant	__ Metal Implants	__ Vision Problems
__ Hearing Impairment	Other: _____	

7. Are you allergic to any medications? Yes No

If yes, please list them: _____

8. Are you allergic to Latex? Yes No Any skin allergies? Yes No

9. Fall History: Injury as a result of a fall in the past year? Yes No Two or more falls in the last year? Yes No

If yes, how and where _____

10. Surgical History: Body Region: _____

Surgery Type: _____ Date (M/Y): _____

11. Current Medications: Drug(s) Dosage_____

Reason for taking _____

Separate list provided Yes No

12. Are you taking any NONPRESCRIPTION medications? (Check all that apply)

___ Advil/Motrin/Ibuprofen
___ Aleve/Naproxen
___ Aspirin
___ Tylenol/Acetaminophen
___ Antacids
___ Antihistamines
___ Decongestants
___ Vitamin/mineral/herbal supplements
___ Other: _____

13. DIAGNOSTIC TESTS: **Please check test(s) for current problem only**.
( ) X-rays ( ) CT scan ( ) MRI ( ) Bone Scan ( ) EMG ( ) Bone Density
( ) Blood Chemistry ( ) Ultrasound ( ) Other (please specify) _____

There are inherent risks associated with physical therapy treatment because you will be asked to exert effort and perform activities with increasing degrees of difficulty, which could cause an increase in your current level of pain or discomfort or aggravate your existing injury. There is also a possibility that you could experience a new injury, but this risk is small. You will be able to stop a procedure if you feel a significant increase in pain or discomfort. You will never be forced to perform any procedure that you do not wish to perform.

Based on the above information, I agree to cooperate fully and to participate in all physical therapy procedures and comply with the plan of care as it is established. I acknowledge that I have read and understand the authorization for treatment.

_____ _____
Patient/Legal Guardian Signature Date

I have reviewed this form with the patient _____ _____
Physical Therapist Signature Date

Please provide all insurance information (cards and forms) to the front desk. All forms must be filled out & signed on the first visit. If there is more than one insurance, information must be provided.

Our financial policy

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about fees, financial policy or your responsibility.

Regarding insurance

If you have insurance, we will help you receive maximum benefits once your coverage has been confirmed and the scope of benefits is defined. It is your responsibility to provide our office with accurate insurance information. If your deductible has not been met, it is your responsibility to meet it; at the time services are rendered. **All payments are due at the time services are rendered.**

Insurance is a contract between you and your insurance company. We file the claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance carrier, other than to supply treatment information as necessary. If your insurance carrier has not paid a claim within sixty (60) days, you will be notified and then have fifteen (15) days to pay the remaining balance.

Missed appointments

Our policy is to charge for missed appointments if not cancelled at least **24 hours** in advance. We never overbook to make up for a no show appointment. We reserve an hour for each of our patients. Please help us serve you better by keeping your scheduled appointments. A **seventy-five dollar** charge will be implemented for missed appointment.

Assignment of insurance benefits

I authorize, assign all benefits and direct that payment be made directly to:

Staten Island Center for Alternative Therapies, LLP
520 Bloomingdale Rd.
Staten Island, NY 10309

For any and all insurance benefits or reimbursement for services rendered by Hands-On Rehabilitation, LLC which amounts otherwise be payable to me under any insurance or pre-paid health care plan.

Release of information

I authorize the release of any information concerning my health and health care services to my insurance companies, pre-paid health plan or Medicare.

It has been fully explained and I understand that Staten Island Center for Alternative Therapies, LLP is an Out of Network Facility.

I clearly understand and agree that all services to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professionally services rendered to me will be immediately due and payable.

Patient Signature _____ **Guardian Signature** _____

Print Name _____ **Relationship to the Patient** _____ **Date** _____

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITYS IN THE FUTURE.

_____ _____

Please ***print*** your name Please ***sign*** your name

_____ _____

Legal Representative Description of Authority

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Sir Name ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

□ Phone Message
□ Text Message
□ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____
Signature of Privacy Officer