ORANGE LAKE PHYSICAL THERAPY, PLLC

211 South Plank Rd. #3, Newburgh, NY 12550 • (845) 566-4303 Fax: (845) 566-4255

PATIENT INFORMATION

First Name _____ Last Name _____
Address _____ City/State/Zip _____
Home Phone # _____ Work Phone # _____ Cell Phone # _____
Date of Birth _____ SS# _____ Drivers License # _____
Male _____ Female _____ Marital Status: M _____ S _____ D _____ W _____
Injured Area _____

How did you hear about us? _____

PLEASE COMPLETE ONLY IF PAYOR IS OTHER THAN PATIENT (IF PATIENT IS A CHILD/MINOR, PLEASE STATE PARENT/GUARDIAN'S EMPLOYER INFORMATION)

Name of Payer/Responsible Party _____
Relationship to Patient _____ SS# _____ D/O/B _____
Employer (Payer not Patient's) _____
Address _____ City/State/Zip _____
Home Phone # _____ Work Phone # _____

PATIENT'S EMPLOYER INFORMATION:

Employer Name _____
Address _____ City/State/Zip _____
Work Phone # _____ Occupation _____
Are you currently working? Y _____ N _____ Retired: Y _____ N _____

Primary Insurance _____ ID# _____ Group # _____
Address _____ City/State/Zip _____
Insurance Carrier Phone # _____ Insured/Policyholder's Phone # _____
Insured/Policyholder's Name _____ D/O/B _____ M _____ F _____
Address _____ City/State/Zip _____
Relationship to patient _____

Secondary Insurance _____ ID# _____ Group # _____
Address _____ City/State/Zip _____
Insurance Carrier Phone # _____ Insured/Policyholder's Phone # _____
Insured/Policyholder's Name _____ D/O/B _____ M _____ F _____
Address _____ City/State/Zip _____
Relationship to patient _____

NAME OF REFERRING PHYSICIAN _____
DATE OF RETURN VISIT TO REFERRING DR. _____ **PRIMARY DR.** _____

PERMISSION TO TREAT A MINOR: I hereby give permission to the staff of Orange Lake Physical Therapy to perform treatment to my child in the event of my absence.

Signature _____ Date _____

Name:_____ Date:_____

Do you now or have you had any of the following: (Please answer Yes or No)

	YES	NO
Breathing Problems	_____	_____
Cancer	_____	_____
Diabetes	_____	_____
High Blood Pressure	_____	_____
Blood Vessel Disease	_____	_____
Heart Attack	_____	_____
Pacemaker	_____	_____
Headaches	_____	_____
Joint Replacements	_____	_____
Metal Implants/Fragments	_____	_____
Arthritis	_____	_____
Nervous System Disorder	_____	_____
Known Allergies	_____	_____
Previous Surgery	_____	_____
Dizziness	_____	_____
Pregnant Now	_____	_____
Infectious Disease	_____	_____
Fractures	_____	_____

If you checked yes to any of the above, please explain and give dates:

_____

_____

List all current medications and state condition that they are used for:

_____

_____

_____

Emergency contact person:

Name:_____

Relaltionship:_____Phone#:_____

The above is correct to the best of my knowledge.

_____ _____

Patient's or Guardian's Signature Date

ORANGE LAKE PHYSICAL THERAPY, PLLC

ASSIGNMENT OF BENEFITS/FINANCIAL POLICY

I hereby authorize the release of any medical information to my insurance company which may be necessary to process my insurance claim. I assign the payment of any medical benefits payable to Orange Lake Physical Therapy. I understand that I am financially responsible for all charges not paid for by insurance, including any and all co-payments, deductibles, collection costs or attorney fees. I understand that it is my responsibility to inform Orange Lake Physical Therapy of any changes in insurance coverage.

Co-payment amount:_____

If a check is returned for insufficient funds, you will be charged the bank fee in addition to the amount of your check which will then be due in cash. If you have any balance due on your account and it has not been paid within 90 days (unless other financial arrangements have been made), the account will be turned over to collections. Collection agency's charge 33% of the unpaid balance due. Should these additional costs be incurred, you will be responsible for the unpaid balance due plus the 33 %.

I understand and agree to comply with the Financial Policy explained above.

_____

Signature of Patient or Guardian (if minor)

ORANGE LAKE PHYSICAL THERAPY, PLLC

APPOINTMENT POLICY AGREEMENT

I understand that my doctor has prescribed physical therapy for me and that physical therapy is an ongoing process which requires regular attendance to be optimally effective. Consequently, I am aware that not attending scheduled sessions may be jeopardizing my progress and also may adversely affect my disability status (no-fault and workers compensation).

PLEASE BE ON TIME FOR YOUR APPOINTMENTS SO THAT YOU MAY RECEIVE THE FULL BENEFIT OF YOUR SCHEDULED TREATMENT. LATE ARRIVAL OF 15 MINUTES OR MORE MAY RESULT IN A SHORTENED OR CANCELLED TREATMENT. We require 24 hours notice for cancellations. Multiple late arrivals, cancellations and/or "no-shows" will result in scheduling you on a call-in basis. Please schedule appointments at the end of the initial evaluation. We will schedule all of your appointments at once for your convenience. If you do not schedule all appointments at once, please do not assume that you automatically have the same appointments each week.

Signature:_____ Date:_____

ORANGE LAKE PHYSICAL THERAPY, PLLC

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have reviewed the Notice of Privacy Practices:

Patient Name (Print):_____

_____ _____

Patient or Personal Representative Signature Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to patient:

_____

For Office Use Only

Documentation of Good Faith Efforts

Patient Name:_____ Date:_____

The patient presented for his/her procedure on this date and has reviewed a copy of the Orange Lake Physical Therapy, PLLC Notice of Privacy Practices. A good faith effort was made to obtain a written acknowledgement of review of the Notice. However, an acknowledgement was not obtained because:

_____Patient refused to sign

_____Patient was unable to sign because of medical reasons or emergency (will attempt to obtain acknowledgement at the next available opportunity).

_____Other reason _____

Signature of employee:_____ _____