# MOVEMENT CONCEPTS PHYSICAL THERAPY

WHERE MOVEMENT IS YOUR MEDICINE

## Patient Demographic Form

### PATIENT INFORMATION

Name (First, MI, Last): Date of Birth (mm/dd/yyyy):

Street Address: City: State: Zip Code:

Home Phone: Cell Phone: Email:

Marital Status: Gender:

○ Single ○ Married ○ Divorced ○ Widowed ○ Separated ○ Partner ○ Other ○ Male ○ Female

### EMERGENCY CONTACT

Name: Relationship to Patient: Home Phone: Cell Phone:

### REFERRAL INFORMATION

Referred By: (If not referred, how did you hear about us?)

Referring Physician's Name: Physician Phone/ Fax (if known)

Physician's Address:

### INSURANCE INFORMATION

Primary Insurance Company: Policy ID #

Secondary Insurance Company: Policy ID #

Name of Subscriber (if other than self): Subscriber Date of Birth (mm/dd/yyyy):

Patient's Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other (Please Specify):

Are you currently working? ○ Yes ○ No

Did the injury occur at: ○ Work ○ School ○ Car Accident ○ Other

### ACKNOWLEDGEMENT

By signing below, I acknowledge that the information I provided is correct to the best of my ability.

Patient Signature: Date:

Guarantor Signature (if other than patient)

Patient#_____ Provider_____

# PHYSICAL THERAPY INITIAL EVALUATION FORM

**PATIENT INFORMATION**

DATE_____

NAME_____ OCCUPATION_____
(LAST) (FIRST)

BIRTHDATE_____ AGE_____ HEIGHT_____ WEIGHT_____lbs

HOME/CELL PHONE_____ EMPLOYER_____

CURRENTLY EMPLOYED? O YES O NO O MODIFIED

**REHAB INFORMATION**

1. CHIEF COMPLAINT/AILMENT/INJURY_____

2. DATE OF INJURY_____ DATE OF SURGERY_____

3. BRIEFLY DESCRIBE HOW YOU WERE INJURED

_____

_____

4. HAVE YOU RECEIVED THERAPY FOR THIS CONDITION? O YES O NO WHEN?_____

HOW MANY VISITS?_____

5. HAS YOUR CONDITION BEEN GETTING: O WORSE O SAME O BETTER

6. ARE YOUR SYMPTOMS: O CONSTANT OR O INTERMITTENT

7. MARK THE NUMBER THAT BEST CORRESPONDS TO YOUR PAIN:

AT BEST: O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10 (EXCRUCIATING PAIN)

AT WORST: O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10 (EXCRUCIATING PAIN)

8. WHAT DECREASES/MAKES YOUR CONDITION BETTER? (MARK ALL THAT APPLY)

| | | | |
|---|---|---|---|
| ☐ BENDING | ☐ MOVEMENT | ☐ REST | ☐ BETTER IN AM |
| ☐ SITTING | ☐ STANDING | ☐ HEAT | ☐ BETTER AS DAY PROGRESSES |
| ☐ RISING | ☐ WALKING | ☐ ICE | ☐ BETTER IN PM |
| ☐ CHANGING POSITIONS | ☐ LYING | ☐ MEDICATION | ☐ N/A CAST JUST REMOVED |

9. WHAT INCREASES/MAKES YOUR CONDITION WORSE? (MARK ALL THAT APPLY)

| | | | |
|---|---|---|---|
| ☐ BENDING | ☐ MOVEMENT | ☐ REST | ☐ SNEEZE |
| ☐ SITTING | ☐ STANDING | ☐ STAIRS | ☐ DEEP BREATH |
| ☐ RISING | ☐ WALKING | ☐ COUGH | ☐ MEDICATION |
| ☐ PROLONGED POSITIONING | ☐ LYING | ☐ WORSE IN AM | ☐ WORSE IN PM |
| ☐ WORSE AS DAY PROGRESSES | ☐ N/A CAST JUST REMOVED | | |

10. PREVIOUS MEDICAL INTERVENTION (MARK ALL THAT APPLY)

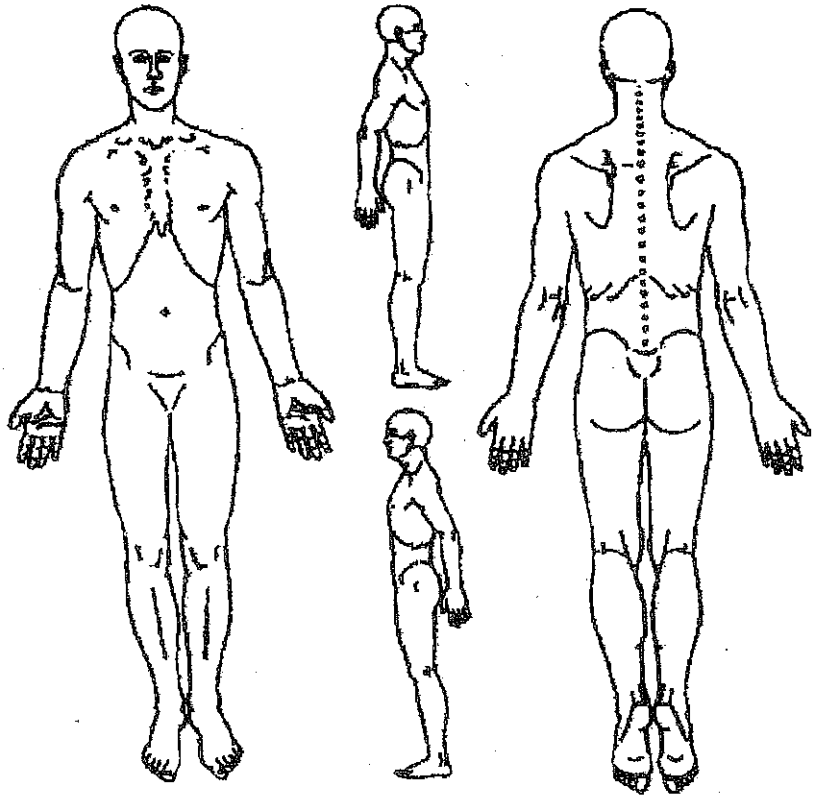
☐ X-RAY MRI ☐ CATSCAN ☐ INJECTIONS OTHER_____

11. WHAT ARE YOUR GOALS TO BE ACHIEVED BY THE END OF THERAPY?

_____

_____

**DRAW IN AREAS OF PAIN ON BODY DIAGRAMS USING APPROPRIATE SYMBOLS. If you are completing this form on the computer, print form after completion and mark the diagram with a pen.**



| | |
|---|---|
| SEVERE PAIN | ******* |
| MODERATE PAIN | 00000000 |
| DULL ACHE | ∩∩∩∩∩∩ |
| RADIATING PAIN | ↑↓↑↓↑↓↑↓ |
| NUMBNESS/TINGLING | XXXXXX |

**MEDICAL INFORMATION** (MARK ALL THAT APPLY) **THIS INFORMATION IS CONFIDENTIAL AND REMAINS PART OF YOUR CHART

| | | |
|---|---|---|
| ☐ DIFFICULTY SWALLOWING | ☐ MOTION SICKNESS | ☐ STROKE |
| ☐ ARTHRITIS | ☐ FEVER/CHILLS/SWEATS | ☐ OSTEOPOROSIS |
| ☐ HIGH BLOOD PRESSURE | ☐ UNEXPLAINED WEIGHT LOSS | ☐ ANEMIA |
| ☐ HEART TROUBLE | ☐ BLOOD CLOTS | ☐ BLEEDING PROBLEMS |
| ☐ PACEMAKER | ☐ SHORTNESS OF BREATH | ☐ HIV/HEPATITIS |
| ☐ EPILEPSY/SEIZURES | ☐ HISTORY OF SMOKING | ☐ HISTORY OF ALCOHOL ABUSE |
| ☐ HISTORY OF DRUG ABUSE | ☐ DIABETES | ☐ DEPRESSION/ANXIETY |
| ☐ MYOFASCIAL PAIN | ☐ FIBROMYALGIA | ☐ PREGNANCY |
| ☐ CANCER | | |

PREVIOUS SURGERIES: _____

OTHER: _____

MEDICATIONS:

_____

_____

ALLERGIES: _____

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW**
**ASSIGNMENT OF BENEFITS FORM**

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____, **("Assignor") hereby assign to** Kristin Confort i, **("Assignee")**
(Print patient's name) (Print hospital or health care provider name)
**all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.**

**The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____, not withstanding any other agreement**
(Print accident date)
**to the contrary.**

**This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.**

**ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.**

_____ _____
**(Print name of Patient)** **(Signature of Patient)**

_____ _____
(Date of signature)

_____
(Address of Patient)

Kristin Confort i _____
**(Print name of Provider)** **(Signature of Provider)**

77 N. Centre Ave Suite 303 _____
Rockville Centre NY 11570 (Date of signature)
(Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)

MOVEMENT CONCEPTS PHYSICAL THERAPY
WHERE MOVEMENT IS YOUR MEDICINE

**Bayport,** NY 11705 • 749 Montauk Highway Phone (631) 313-8872 Fax (631) 363-4157
**Bayside,** NY 11358 • 35-16 Francis Lewis Blvd Unit A Phone (718) 428-3500 Fax (718) 428-0800
**Carle Place,** NY 11514 • 1 Old Country Rd. Suite PL01 Phone (516) 227-5344 Fax (516) 227-5339
**Rockville Centre,** NY 11570 • 77 Centre Ave, Suite 303 Phone (516) 321-9321 Fax (516) 608-2920

## No Fault Insurance Registration Form

Name of Insurance Carrier: _____

Insurance Carrier Claims Address: _____

_____

Insurance Carrier Phone #: _____ Fax Number: _____

NF Claim # _____

Date of Accident _____ In which state did the accident occur? _____

Date of Surgery, if applicable _____

_____

Adjuster Name: _____

Adjuster Phone #: _____ ext _____ Fax Number: _____

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Do you have an attorney? Y or N

If Yes, Attorney's Name: _____

Attorney # _____ Fax Number: _____

# Movement Concepts Physical Therapy

**Responsibility Form Patient Guarantor & Financial**

Welcome to Movement Concepts Physical Therapy. Thank you for choosing our facility to help serve you with quality and personalized care for your rehabilitation needs. Please read the following information to help you understand your financial responsibilities.

**Your signature on this form indicates that you accept the following statements.**

**Arrival:** Please arrive on time for all appointments. If you are going to be late please call.

**Scheduling:** Please schedule your next appointment(s) before you leave.

**Cancellation:** If you are unable to attend a treatment session, please notify us at least twenty-four hours prior to your appointment time or you will be charged a $50 cancellation fee.

**Patient / Guarantor Responsibility:** Payment for all professional services rendered is the responsibility of the patient, parent or guardian. Movement Concepts Physical Therapy will assist in the preparation of insurance forms to help expedite insurance payments and verify your benefits. **The patient is responsible, however, for all fees regardless of insurance coverage.** You are responsible for payment of any deductible, co-payment, and co-insurance as stated by your contract with your insurance carrier. If your insurance carrier denies any part of your claim, or, if after consulting with your physician, the need exists to continue therapy beyond the approved coverage by your insurance carrier, you will be responsible for your account balance in full. If it is necessary to refer the account to our collection attorneys, the patient agrees to pay the cost of all collection fees including attorney's fees.

## CONSENT FOR CARE AND TREATMENT

I, hereby agree and give consent to Movement Concepts Physical Therapy to furnish medical care and treatment necessary and proper in diagnosing or treating his/her physical condition.

## HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

I authorize my medical information to be released to the following:

1. Primary Care Physicians, other Physicians & Medical Staff involved in our care
2. Physical Therapists & Occupational Therapists involved in your care
3. School Nurses involved in your care
4. Orthotics involved in your care
5. Athletic Trainers & Coaches involved in your care
6. Worker's Compensation Physicians, Nurses, and Case Managers involved in your care
7. Insurance Companies and/or other payers involved in your case
8. Attorneys involved with your case

**Are there any privacy issues that we need to be aware of? YES / NO**

I make the following request for confidential communications:

_____

Movement Concepts Physical Therapy has made available for review a copy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) with regard to the use and/or disclosure of certain protected health information about me.

**PATIENT NAME:** (Please Print)_____

**PATIENT SIGNATURE:**_____ **Date:**_____

(Parent/ Legal Guardian or Guarantor's signature if patient is not the guarantor or a minor)

# Movement Concepts

## PHYSICAL THERAPY

### NOTICE TO ALL PATIENTS:

**In order to avoid confusion, we would like to make you aware that some CPT codes involving a technique called (Strapping/ Taping) depending on the insurance company may reflect a "surgical code". These codes do not mean that surgery was performed or billed but the codes may show up under that category on your eobs.**

**Strapping refers to the application of overlapping strips of adhesive plaster or tape to a body part to exert pressure and hold a structure in place. Whether it be for the purpose of assisting/facilitating movement or for the purpose of immobilizing an area, for soft tissue treatment of fractures, dislocations, sprains/strains, tendonitis, post-op reconstruction, contractures, or other deformities involving soft tissue . Depending on the purpose of the technique performed different codes are billed. Below are examples of what may be used.**

### CPT code:

| | |
|---|---|
| 29200 | Strapping; thorax |
| 29240 | Strapping ; shoulder (eg, Velpeau) |
| 29260 | Strapping; elbow or wrist |
| 29520 | Strapping; hip |
| 29530 | Strapping; knee |
| 29799 | Unlisted procedure, casting or strapping |
| 29280 | Strapping; hand or finger |
| 29540 | Strapping; ankle and/or foot |
| 29550 | Strapping; toes |
| 97139 | Unlisted therapeutic procedure code |
| 97799 | Unlisted physical medicine/rehabilitation service or procedure |

PATIENT SIGNATURE:_____ DATE:_____

**Movement Concepts** in Physical Therapy
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# CANCELLATION POLICY

This policy has been established in order to provide the highest level of Physical Therapy Service to all our patients. It has been proven that consistent attendance provides for the greatest opportunity for success.

1. **Cancellation/No Show Policy**

   We understand that there are times when you must miss an appointment due to emergencies, illness, or obligations for work and family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment.

   **If an appointment is not canceled at least 24 hours in advance you will be charged a fifty dollar fee ($50); this is not covered by your insurance company.**

2. **Scheduled Appointments**

   We understand that delays can happen. We must however, try to maintain our scheduled bookings every 15 minutes, to ensure therapists have the appropriate amount of time to spend individually with each patient.

   **If a patient is 15 minutes past their scheduled time, we reserve the right to reschedule your appointment if the therapist does not have availability.**

***I hereby acknowledge the terms and conditions listed above.***

_____ **Print Name**

_____ **Patient/Guardian Signature**

__/__/__ **Date**