



Dear Patient,

As you may be aware, physical therapy rehabilitation may sometimes include a series of exercises that you will be expected to continue at home. Therefore, we like to give our patients advance notice that you may be required to purchase additional exercise implements such as resistance bands, resistance tubing, exercise balls, etc. These items will not be covered by your insurance and will be the responsibility of the patient. For your convenience, this equipment is available for purchase at our office but, please feel free to purchase these exercise tools elsewhere. Below is a list of the equipment that is available for purchase at our office:

Price List

Exercise Ball - \$20.00

Exercise Bands - \$5.00

Exercise Tubing - \$8.00

Buchberger-12 Manual - \$21.95 +tax

Buchberger-12 DVD - \$34.95 +tax

DVD and Manual - \$49.95 +tax

We would be glad to answer any questions that you have. Thank you for your attention and we look forward to being your **active** physical therapy **solution!**

Sincerely,

Active P.T. Solutions Staff

ACTIVE PHYSICAL THERAPY SOLUTIONS PC

Westlake Ave. Auburn, NY 13021 (315) 515-3117 F: (315) 515-3121

Office Hours: Mon 8:30am-5:30pm, Tues 10:00am-7:00pm, Wed 8:30am-5:30pm, Thurs 8:30am-5:30pm, Fri 8:30am-4:00pm

***In an effort to keep the office running as efficiently as possible, this paperwork needs to be completely filled out when you arrive for your appointment. If it's not complete, your appointment will be rescheduled. We also ask that you arrive 15 minutes early for your appointment so we can check you in. Thank you for your co-operation!**

Patient Information

Please Print

Name _____ Nickname _____

Sex _____ DOB _____ Age _____ SS# _____

Address _____ City, State, Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Occupation _____

Employer Address _____ City, State, Zip _____

Retired _____ Date of Retirement _____ Former Occupation _____

Email Address: _____

Marital Status Married, Single, Separated, Divorced, Widowed, Other, _____

Primary Insurance Information

Name and Address of Insurance Company _____

Name of Insured _____ Relationship to Patient _____

Employer _____ DOB of insured _____

Policy # _____ Group # _____

Secondary Insurance Information

Name and Address of Insurance Company _____

Name of Insured _____ Relationship to Patient _____

Employer _____ DOB of insured _____

Policy # _____ Group # _____

Primary Doctor Information

Primary Doctor Name _____ Phone # _____

Doctor's Address _____

Date of last visit _____

Review of Systems

Family - Personal - Medical Histories

Patient Name: _____

Date: _____

Please mark any condition or symptoms you have had in the past or are currently experiencing.

General History	Family History	Endocrine System	Eye/Ear/Nose/Throat
<input type="checkbox"/> Trauma/Injuries <input type="checkbox"/> Height Change <input type="checkbox"/> Fever / Chills <input type="checkbox"/> Sweats <input type="checkbox"/> Allergies <input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding / bruising <input type="checkbox"/> Malaise / fatigue <input type="checkbox"/> Weakness <input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid disease <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Kidney disease <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart disease / stroke <input type="checkbox"/> Musculoskeletal disease <input type="checkbox"/> Cancer <input type="checkbox"/> Other	<input type="checkbox"/> Heat / Cold intolerance <input type="checkbox"/> Thyroid problems <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Diabetes <input type="checkbox"/> Type I (Juvenile) <input type="checkbox"/> Type II (Adult) <input type="checkbox"/> Neck surgery / irradiation <input type="checkbox"/> Other	<input type="checkbox"/> Visual problems <input type="checkbox"/> Eye irritations <input type="checkbox"/> Pain in the eyes <input type="checkbox"/> Other eye problems <input type="checkbox"/> Difficulty hearing / deaf <input type="checkbox"/> Ringing in ears / dizziness <input type="checkbox"/> Ear growth / discharge <input type="checkbox"/> Ear pain

Eye/Ear/Nose/Throat (cont)	Cardiovascular System	Cardiovascular System (cont)	Gastrointestinal System
<input type="checkbox"/> Nose bleeds <input type="checkbox"/> Change in ability to smell <input type="checkbox"/> Sneezing <input type="checkbox"/> Nose growths / discharge <input type="checkbox"/> Nose pain <input type="checkbox"/> Sinusitis	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Time of day _____ <input type="checkbox"/> How often _____ <input type="checkbox"/> Chest discomfort / pain <input type="checkbox"/> Type _____ <input type="checkbox"/> How often _____ <input type="checkbox"/> Sudden calf pain/while walking <input type="checkbox"/> How often _____	<input type="checkbox"/> High blood pressure <input type="checkbox"/> Past heart disease <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Other problems	<input type="checkbox"/> Change in appetite <input type="checkbox"/> Food intolerance <input type="checkbox"/> Nausea / Vomiting <input type="checkbox"/> Vomiting of blood <input type="checkbox"/> Peptic Ulcer <input type="checkbox"/> Indigestion / Heartburn <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Abdominal swelling <input type="checkbox"/> Gas <input type="checkbox"/> Change in stool/color/etc.

Gastrointestinal System (cont)	Urinary System	Urinary System (cont)	Respiratory System (cont)
<input type="checkbox"/> Diarrhea <input type="checkbox"/> Hernia <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Gallbladder disease <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Alcohol intake <input type="checkbox"/> Type _____ <input type="checkbox"/> Amount _____ <input type="checkbox"/> Other	<input type="checkbox"/> Frequent urination <input type="checkbox"/> Day/ _____ night <input type="checkbox"/> Daily fluid intake _____ <input type="checkbox"/> Pain on urination <input type="checkbox"/> Change in urine color / etc <input type="checkbox"/> Difficulty in starting stream <input type="checkbox"/> Difficulty in holding urine <input type="checkbox"/> Discharge <input type="checkbox"/> Flank pain	<input type="checkbox"/> Urinary tract infections <input type="checkbox"/> Kidney disease <input type="checkbox"/> Pelvic pain <input type="checkbox"/> Other problems Respiratory System <input type="checkbox"/> Difficulty in breathing <input type="checkbox"/> Cough <input type="checkbox"/> Blood in sputum <input type="checkbox"/> Wheezing/asthma	<input type="checkbox"/> Tuberculosis / exposure <input type="checkbox"/> Pneumonia / lung infections <input type="checkbox"/> Cigarette smoking history Daily # _____, yrs _____ <input type="checkbox"/> Other tobacco use Cigar _____ Pipe _____ Chewing tobacco _____ Amount _____ yrs _____ Environmental exposure Type _____ Amount _____

Please mark any condition or symptoms you have had in the past or are currently experiencing.

<p>Neurological System</p> <p><input type="checkbox"/> Headaches <input type="checkbox"/> Epileptic seizures <input type="checkbox"/> Tics / spasm <input type="checkbox"/> Dizziness / fainting <input type="checkbox"/> Disturbances of sensation <input type="checkbox"/> Unusual weakness <input type="checkbox"/> Head trauma <input type="checkbox"/> Stroke <input type="checkbox"/> Other problems</p>	<p>Musculoskeletal</p> <p><input type="checkbox"/> Joint stiffness / decreased motion <input type="checkbox"/> Joint pain <input type="checkbox"/> Joint swelling <input type="checkbox"/> Muscle cramps <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Muscle wasting <input type="checkbox"/> Neck pain <input type="checkbox"/> Mid back pain <input type="checkbox"/> Low back pain</p>	<p>Breast</p> <p><input type="checkbox"/> Bumps / lumps / mass <input type="checkbox"/> Pain / tenderness <input type="checkbox"/> Dimples in breast <input type="checkbox"/> Change in color, size or shape <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Other breast problems <input type="checkbox"/> Implants</p>	<p>Diet / Vitamins</p> <p><input type="checkbox"/> Vegetarian <input type="checkbox"/> Take Supplements _____</p> <p>Implants</p> <p><input type="checkbox"/> Breast implants <input type="checkbox"/> Cardiac pacemaker <input type="checkbox"/> Penile / other _____</p>
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<p>Skin / Hair / Nails</p> <p><input type="checkbox"/> Change in skin texture <input type="checkbox"/> Change in skin temp <input type="checkbox"/> Skin dryness / wetness <input type="checkbox"/> Unusual skin coloration <input type="checkbox"/> Rashes / itching / sores <input type="checkbox"/> Skin growths</p>	<p>Musculoskeletal</p> <p><input type="checkbox"/> Sacroiliac pain <input type="checkbox"/> Tailbone pain <input type="checkbox"/> Arm problem <input type="checkbox"/> Leg pain <input type="checkbox"/> Fracture / dislocations <input type="checkbox"/> Sprain / strains <input type="checkbox"/> Other injuries or problems</p>	<p>Reproductive System</p> <p><input type="checkbox"/> Genital lesions / sores <input type="checkbox"/> Genital mass / growth / pain <input type="checkbox"/> Syphilis <input type="checkbox"/> HIV positive <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Change in sex drive <input type="checkbox"/> Birth control method Type _____ How long? _____</p>	<p>Female Patients</p> <p><input type="checkbox"/> 1st period Age _____ Yr _____ <input type="checkbox"/> Scant flow <input type="checkbox"/> Light flow <input type="checkbox"/> Moderate flow <input type="checkbox"/> Heavy flow <input type="checkbox"/> Days in cycle <input type="checkbox"/> Pain 0 1 2 3 4 5 <input type="checkbox"/> First day of last cycle _____ Date of last pap _____</p>
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<p>Skin / Hair / Nails</p> <p><input type="checkbox"/> Mole growths <input type="checkbox"/> Skin cancer <input type="checkbox"/> Skin pain <input type="checkbox"/> Change in hair texture / condition <input type="checkbox"/> Change in hair growth / loss <input type="checkbox"/> Change in shape of finger / toenails <input type="checkbox"/> Change in nail color <input type="checkbox"/> Other problems</p>	<p>Psychological History</p> <p><input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Hospitalization <input type="checkbox"/> Therapy <input type="checkbox"/> Bipolar Disorder</p> <p>Hospitalization / Meds</p> <p><input type="checkbox"/> Other hospitalizations not listed above <input type="checkbox"/> Current use of any drugs, prescription or recreational</p>	<p>Diet / Vitamins</p> <p><input type="checkbox"/> Do you eat meals sporadically? <input type="checkbox"/> Do you have an unusual appetite <input type="checkbox"/> Large <input type="checkbox"/> Small <input type="checkbox"/> Do you skip breakfast? <input type="checkbox"/> Do you eat between meals? <input type="checkbox"/> Late night snacks? <input type="checkbox"/> Eat junk food <input type="checkbox"/> On a special diet</p>	<p>Female Patients Menopause</p> <p><input type="checkbox"/> Post menopause bleeding <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Premenstrual fluid retention <input type="checkbox"/> # of pregnancies <input type="checkbox"/> # of children <input type="checkbox"/> Difficult delivery <input type="checkbox"/> PMS syndrome <input type="checkbox"/> Hysterectomy Date _____</p>
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Patient Signature _____

Date _____

Patient Health Questionnaire

1. Describe how and when your present symptom (s) started.

How did your symptom (s) start?

1. Gradual onset, no particular injury
2. Work injury
3. Motor Vehicle accident: Car/Truck Motorcycle ATV Boat/Jet Ski Snowmobile
4. Sports Injury: Throwing, Swimming, Running, Golf, Tennis, Other _____
5. Other

When did your symptom (s) start? (day/month/year) _____
(If Work Comp or No Fault, Date of Injury or accident is required)

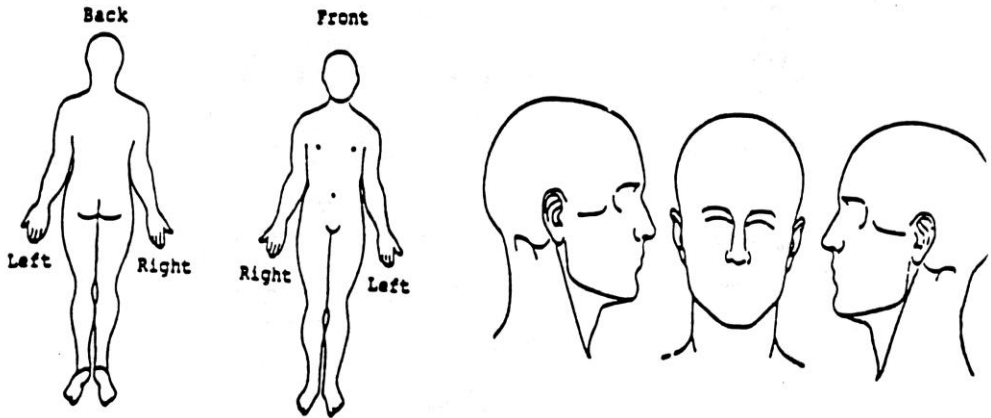
2. Describe your present symptom (s)

3. Have you ever had Physical Therapy for these symptoms? Yes No Initials of Patient _____

If so, where did you go and how long did you attend P.T.? _____

4. On the following diagrams indicate the location of your complaints, using the symbol key.

Ache	Burning	Numbness	Pins & Needles	Stabbing	Other
~~~~~	=====	OOOOOOOO	.....	/////	XXXXXXX



5. Indicate each symptom's intensity by making a slash along the corresponding line from no pain (left) to worst possible pain (right). Also indicate % of the day present and pattern of change.

Symptoms	No Pain (0)	←→	Worst Pain Possible (10)	% of day present				Getting Better	Not Changing	Getting Worse
				0-25	26-50	51-75	76-100			
___ Headache	_____	_____	_____	1	2	3	4	1	2	3
___ Neck Pain	_____	_____	_____	1	2	3	4	1	2	3
___ Lower back pain	_____	_____	_____	1	2	3	4	1	2	3
___ Upper back pain	_____	_____	_____	1	2	3	4	1	2	3
___ Mid back pain	_____	_____	_____	1	2	3	4	1	2	3
___ Other	_____	_____	_____	1	2	3	4	1	2	3
___ Other	_____	_____	_____	1	2	3	4	1	2	3

Patient Name: _____ Date: _____

6. Indicate which of the following activities make your symptom (s) better (^) or worse (/).

- ^ // Sitting      ^ // Bending forward      ^ // Movement / activity      ^ // Laying down  
 ^ // Standing      ^ // Bending backward      ^ // Inactivity      ^ // Reaching Overhead  
 ^ // Computer      ^ // Sleep      ^ // Driving      ^ // Exercise

7. List **ALL** medications **and** vitamin supplements you are currently taking:

Name	Type	Amount taken per day	Condition taken for

Types of medications (Rx – prescription    OTC – over the counter)

- |                           |                                            |
|---------------------------|--------------------------------------------|
| 1. Antidepressant – Rx    | 4. Narcotic / codeine - Rx                 |
| 2. Anti-inflammatory – Rx | 5. Acetaminophen, aspirin, ibuprofen - OTC |
| 3. Muscle relaxant – Rx   | 6. Other – describe above                  |

8. If you have ever had **ANY** surgical procedures, please list to the best of your ability below:

If you are denying ever having a previous surgical procedure, please check box and initial. _____

Name of Procedure	Date performed	Condition performed for

9. Tobacco and alcohol use:

- |                  |                                   |                                    |
|------------------|-----------------------------------|------------------------------------|
| Cigarette usage: | 1. Non-smoker, never smoke        | 4. Smoke 1-2 packs per day         |
|                  | 2. Non-smoker, used to smoke      | 5. Smoke more than 2 packs per day |
|                  | 3. Smoke less than ½ pack per day |                                    |

How many years have you smoked? _____

How many alcoholic beverages (beer, wine, liquor) do you consume in an average week? _____

Has your use of alcohol or other chemicals increased since your symptom (s) began?

1. No                      2. Yes



Active Physical Therapy Solutions PC

**Financial Agreement**

Please write your initials after **EVERY** statement.

I agree to pay for all services rendered. I agree to pay any and all amounts that my insurance company applies to any unmet deductible. If my insurance company requires a co-payment, I agree to pay it at the time of each appointment. If my insurance pays on a percentage basis, I agree to pay an average amount per visit based on what my percentage is. This is to be negotiated and agreed upon with the Associate Director of the office. If my insurance policy allows a certain number of visits for physical therapy or chiropractic services, I am responsible for tracking those visits as well as payment for any treatment given past that allowance. _____

If I have **Medicare**, I understand that I am responsible for my deductible each year and any coinsurance as well as tracking my Medicare financial cap for the year. _____

If this is a **no fault or workers' compensation** claim, I am responsible for submitting all information for submitting a claim. Failure to submit necessary information may result in full payment of services at our private fee rate. I have read and understand the workers' compensation Medical Treatment Guidelines and know my responsibilities as the patient as stated in the guidelines. _____

I understand that I will be fully responsible for any services deemed as non-covered or denied by my insurance company. I recognize and accept complete financial responsibility for any balance remaining after the payment of correct benefits by an insurance company. _____

I understand that I'm responsible for verifying that Active Physical Therapy Solutions PC is in-network with my insurance. If my insurance company is **out-of-network** with Active Physical Therapy Solutions PC, and there is a limit on the number of units per visit, I agree to pay the difference between what is paid by my insurance company and the services rendered by Active Physical Therapy Solutions PC _____

I understand that exercise equipment such as exercise balls, bands, and tubing that is sold in this office, **will not** be billed to my insurance company and can be necessary for rehabilitation purposes. Educational materials such as DVD's, manuals, etc. are **not reimbursable** by any form of health insurance and **are subject** to NY state and county sales tax. I understand that educational and rehabilitation materials are my sole financial responsibility and will not be released without payment. _____

If I am **uninsured**, or become uninsured during the course of treatment, I understand that I am responsible for payment in full at the time of service, unless prior arrangements have been made with the Associate Director of the office. _____

**I assign insurance benefits** for all services rendered by permitting payment directly to Active Physical Therapy Solutions PC, for services rendered. _____

Payment can be made in the form of cash, check, and/or credit card (Visa or MasterCard). There will be a \$25.00 per check charge for all returned checks.

**We ask to keep your credit card number or HSA number on file as insurance for payment of co-pays, deductibles, or chronically missed appointments. Your account information will be kept in a secure place and will not be charged without discussing any outstanding balances delinquent beyond 60 days. This is not required, but in the past has been a very convenient payment method for us as well as our patients.**

**VS or MC (circle one)      Name on Card** _____

**Card #** _____ **Exp. Date** _____

**Verification Code** _____

I certify that I am 18 years of age and/or the legal guardian/guarantor. I understand and accept full financial responsibility for the patient listed below.

**Printed Name of Patient** _____ **Date** _____

**Signature of Patient and/or Legal Guardian** _____

**Policies & Procedures**

**Authorization for Medical Information Release**

I authorize Active Physical Therapy Solutions PC to furnish my insurance company with medical information they may request regarding my condition or treatment. I authorize my referring health care provider to release any diagnostic reports and/or surgery reports to Active Physical Therapy Solutions PC. Furthermore, I authorize Active Physical Therapy Solutions PC to release any treatment reports to the referring physician as it corresponds with the physical therapy prescription.

I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that Active Physical Therapy Solutions PC will retain the ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies. Images that identify me will be released and/or used outside the practice only upon written authorization from me or my legal representative.

**Authorization of Treatment**

I hereby authorize treatment of the below-named patient by Active Physical Therapy Solutions PC.

I understand that any patients under the age of 18 **must be accompanied to the initial physical therapy or chiropractic evaluation by the parent or legal guardian of the patient.** Failure to comply may result in rescheduling your appointment.

**Privacy Notice & Patient Bill of Rights**

I have read and understand Active Physical Therapy Solutions PC Notice of Privacy Practices and Patient Bill of Rights.

I certify that I am 18 years of age and/or the legal guardian/guarantor of the patient named below.

Designated persons to aid in patient care or to communicate medical information in the case of an emergency:

Name: _____ Relationship: _____

Phone #: _____

Name: _____ Relationship: _____

Phone #: _____

**Printed Name of Patient** _____ **Date** _____

**Signature of Patient and/or Legal Guardian** _____

Active Physical Therapy Solutions PC

**Cancellation Policy**

The success of your treatment is important to us. In order to have a successful treatment plan your attendance is imperative. In an effort to accommodate the treatment schedule for all patients, we request that you call at least 24 hours prior to your appointment to cancel or reschedule. **If you cancel or no show three or more consecutive appointments, your future appointments will be cancelled** and a letter will be sent to you, to serve as a record of your attendance and allow you to communicate with our staff in an effort to improve your attendance and improve your quality of care.

I understand that a \$25.00 fee will be assessed for each appointment that I schedule but do not attend, or that is rescheduled with less than 24 hour advance notice. Active Physical Therapy Solutions PC reserves the right to waive such fees as a courtesy in the event of severe weather, health emergencies and special circumstance. **This fee is not reimbursable by your insurance carrier and is due at your next visit.**

Please feel free to discuss any questions or concerns with the Associate Director of Active Physical Therapy Solutions PC and thank you for your cooperation on this very important matter!

I have read, understand and agree to the Active Physical Therapy Solutions PC Cancellation Policy. It has been explained to me and my questions have been answered to my satisfaction.

**Printed Name of Patient** _____ **Date** _____

**Signature of Patient and/or Legal Guardian** _____