Pequa Physical & Aquatic Therapy 2848 Middle Country Rd, Lake Grove NY 11776
Your pain relieved. Your life restored. 913 North Broadway, Massapequa NY 11758

New Patient Intake Form:

Demographics

First Name: _____ **Last Name:** _____

Date of Birth: _____ **Social Security #:**_____

Gender: Male Female Other **Marital Status:** Single Married Divorced Widowed

Address: _____ **Apt #**: _____

City: _____ **State:** _____ **Zip code:**_____

Contact Information

How Did You Hear About Us? Internet Friend/Family Referring Physician Other_____

Home Phone: _____ **Cell Phone:** _____

Preferred phone number: Home or Cell

Emergency Contact Name: _____ **Relationship:** _____

Emergency Contact Phone #: _____

Doctor Information

Primary Care Physician: _____ **PCP Phone #:** _____

Referring Physician: _____**Referring Phone #:**_____

Insurance Information

Primary Insurance: _____**Member ID:** _____

Group#: _____ **Provider Line Phone #:**_____

Secondary Insurance: _____ **Member ID:** _____

Group#: _____ **Provider Line Phone #:**_____

Print Name: _____

Signature: _____ Date: _____

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Patient Acknowledgement of Receipt of Privacy Practices Notice

This notice describes how medical information about you may be used or disclosed and how you can get access to information, please review it carefully. It is the legal duty of Pequa Physical and Aquatic Therapy to protect the confidentiality of your personal health information. We are required to provide you with this notice which outlines our policies and procedures.

USES AND DISCLOSURES OF HEALTH INFORMATION

Pequa Physical and Aquatic Therapy, hereafter referred to as the Practice, uses your personal health information (PHI) in order to provide treatment to you, to be able to obtain payment for your treatment, to perform administrative activities within the practice, and for being able to determine the quality of care that is provided to you. PHI is all the personal information that can identify you: your name, address, telephone number, social security number, health policy number, etc. For example, we may use your PHI to call you to remind you about an appointment or to contact your insurance company for payment, speak to your Doctor about your program, or just call you into the treatment area from the waiting room.

The practice may use your PHI without prior authorization when we are required to do so by law, if there is a public health concern, if you have a communicable disease, if we believe that there is abuse or neglect, for research studies, for legal proceedings, for law enforcement, if a crime occurs in the Practice's office, if an emergency occurs, to funeral directors and coroners, for military activity and national security, and for worker's compensation.

It is policy of Pequa Physical and Aquatic Therapy to get a signed authorization from you prior to releasing your PHI. You have the right to either agree or object to the release of your information. If you agree and sign a written authorization, you have the right to take back the authorization at a later date if you choose to. If you are not actually present, or unable to agree or disagree, to the disclosure of information, the Practice can then use it's professional judgment to decide if the disclosure is in your best interest.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to inspect and ask for a copy of your personal health information at any time. You have the right to ask us to make changes or corrections in your information. The Practice does not have to comply with your request. You have the right to file a disagreement with the Privacy Officer.

You may request a list of all the disclosures that we have made of your PHI after April 14, 2009 for any reason other than for treatment, billing, or administrative activities of the practice.

You also have the right to ask in writing that the Practice not disclose your PHI except when authorized by you, required by law or in the case of an emergency. You may also request that your PHI is not disclosed to family members or friends that may be involved in your care. The Practice will consider all such request, but is not required to agree or act on them. You have the right to have confidential information sent to you at an alternative location or by a means other than the postal service. You have the right to obtain a copy of this notice.

CONCERNS AND COMPLAINTS

If you feel that your privacy rights have been violated at any time or you do not agree with how your PHI is being disclosed, you can contact our Privacy Officer at the address listed below. The Practice will not retaliate against you for filing a complaint. You can also contact the Secretary of Health and Human Services.

The terms of this notice may change at any time. A copy of the revised notice will be posted in the office in easily accessible areas and will be provided to you upon your request. This notice was published on January 01, 2010.

Print Name: _____

Signature: _____ Date: _____

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Financial Terms and Conditions

Pequa Physical and Aquatic Therapy will bill your insurance carrier at our contracted rates. If a co-payment is due, you will be responsible for meeting your payment after each visit. Please be aware of your insurance policy provisions. If our facility is denied payment for any reason due to these provisions, you will be responsible to pay us for the denied visits. If you have any questions about which limitations apply to you, please ask the billing department or contact your insurance directly. Once your insurance benefits are exhausted, if you wish to continue physical therapy, you will be responsible for our private fee. If we decide to go out of network with your insurance, the checks will be addressed and could be mailed to you and it will be your responsibility to sign them off and either mail or deliver them to us.

In the event that this account should be placed in the hands of an outside attorney for collection, the responsible party agrees to pay all outside costs of collection, including reasonable attorneys' fees not to exceed 20% of the unpaid balance together with court costs and disbursements.

I have also advised Pequa Physical and Aquatic Therapy that my condition being treated is NOT directly related to work and/or an on the job injury, NOR is due to a motor vehicle accident.

□ I, _____ am aware that Pequa Physical and Aquatic Therapy is billing IN-NETWORK for provided services. I understand that my copayment/ co-insurance will be $_____.00 a visit until further notice, or until my deductible/ out-of-pocket has been met.

OR

□ I, _____ am aware that Pequa Physical and Aquatic Therapy is billing OUT-OF-NETWORK for provided services. I understand that my copayment will be $_____.00 a visit until further notice, or until my deductible/ out-of-pocket has been met. *Since all insurance payments will be mailed to me, I understand that I am obligated to bring and sign over all payments to Pequa Physical and Aquatic Therapy.*

Print Name: _____

Signature: _____ Date: _____

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Medical History

Past Surgical History

Surgery	Reason/Body Part	Year

Medication List

Medication Name	Dosage	Frequency Taken

Allergies

Please list anything that you are allergic to (medications, food, etc.) and how it affects you.

_____

_____

_____

Diagnostic Imaging

Have you received any diagnostic imaging for your current injury/condition? ❒ Yes ❒No

If yes, which body part and where was it done? (Specify which company and which town)

_____

Print Name: _____

Signature: _____ Date: _____

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Medical History

Are you under a physician's care now? ❒ YES ❒ NO
If Yes, Explain: _____

Have you ever been hospitalized or had a major operation? ❒ YES ❒ NO
If Yes, Explain: _____

Have you ever had a serious neck or head injury? ❒ YES ❒ NO
If Yes, Explain: _____

Are you on a special diet? ❒ YES ❒ NO
If Yes, Explain: _____

Do you use tobacco? ❒ YES ❒ NO If Yes, How Often: _____

Do you currently use recreational or street drugs? ❒ YES ❒ NO
If Yes, Explain: _____

Do you use controlled substances? ❒YES ❒ NO
If Yes, Explain: _____

Have you been on Cortisone Medicine for more than 6 weeks? ❒ YES ❒NO

Women: are you pregnant or nursing? ❒YES ❒ NO

Is this injury/condition related to work? ❒ YES ❒NO

Is this injury/ condition related to an Auto Accident? ❒ YES ❒ NO

Have You Had Physical Therapy before for this injury/condition? ❒ YES ❒ NO
If Yes, when and where: _____

How often do you exercise? ❒NEVER ❒ OCCASSIONALLY ❒ MODERATELY ❒ HIGH LEVEL

How often do you drink alcohol? ❒ Never ❒ Less than 3X/WK ❒ More than 3X/WK

Print Name: _____

Signature: _____ Date: _____

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Medical History

Please check ✓ if you have, or have you had any of the following

AIDS / HIV Positive		Hemophilia	
Alzheimer's Disease		Hernia	
Anemia		Herpes	
Any Pins or Medical Implants		Hepatitis A, B or C	
Arthritis/Rheumatoid Arthritis		High Cholesterol	
Artificial Joint		High Blood Pressure	
Asthma		Hives or Rash	
Blood Disease		Hypoglycemia	
Blood Transfusion		Irregular Heartbeat	
Blood Clot/Emboli		Kidney Problems	
Bowl or Bladder Problems		Leukemia	
Breathing Problems		Liver Disease	
Bruise Easily		Low Blood Pressure	
Cancer		Lung Disease	
Chemotherapy/Radiation		Numbness or Tingling	
Chest Pains/ Shortness of Breath		Multiple Sclerosis	
Cold Sores/Fever Blisters		Osteoporosis/Osteopenia	
Congenital Heart Disorder		Pain In Jaw	
Do You Smoke?		Psychiatric Care	
Diabetes		Renal Dialysis	
Drug Addiction		Shingles	
Emphysema		Sickle Cell Disease	
Epilepsy or Seizures		Sinus Trouble	
Excessive Bleeding		Sleeping Problems	
Fainting/Dizziness		Stomach/Intestinal Disease	
Fibromyalgia		Spina Bifida	
Frequent Cough		Spinal Cord Injury	
Frequent Diarrhea		Stroke	
Genital Herpes		Swelling Of Limbs	
Glaucoma		Thyroid Disease	
Gout		Tuberculosis	
Heart Attack/Failure		Tumors Of Growths	
Heart Murmur		Ulcers	
Heart Pacemaker		Vision or Hearing Difficulties	
Heart Trouble/ Disease		Venereal Disease	

Print Name: _____

Signature: _____ Date: _____

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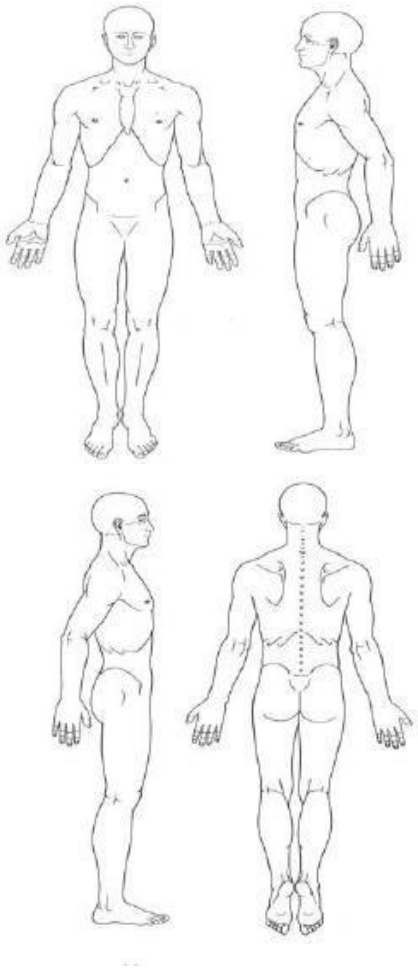
Pain Assessment

Please Indicate Where You Have Pain Or Other Symptoms



Please identify on a scale of 0-10 (0 being no pain, 10 being unbearable pain)

PRESENT: _____/10 AT BEST: _____/10 AT WORST :_____/10

1. Describe your symptoms: _____

_____

_____

_____

_____

2. How Did Injury Occur: _____

_____

_____

_____

_____

3. When Did Injury Occur: _____

_____

_____

How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

Are you aware of your diagnosis (what you are being treated for at our clinic)? ❒ Yes ❒ No

Print Name: _____

Signature: _____ Date: _____

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Aqua Therapy Screen

Please Check ✓ The Box Below If You Have Any Of The Following:

- ❒ Typhoid, Cholera, Dysentery, Or Any Other Waterborne Disease
- ❒ Fever Higher Than 100° F
- ❒ Kidney Disease
- ❒ Stomach Of Intestinal Disorder
- ❒ Infectious Disease
- ❒ Open Wounds
- ❒ Skin Rashes
- ❒ Perforated Ear Drums
- ❒ Incontinence
- ❒ Difficulty Breathing
- ❒ Epilepsy
- ❒ Radiation Treatment Within The Last 3 Months
- ❒ High Blood Pressure
- ❒ Heart Disease
- ❒ Pacemaker or Defibrillator

Print Name: _____

Signature: _____ Date: _____