Achieve
Physical Therapy & Aquatic Therapy

4654 Onondaga Boulevard, Suite 1
Syracuse, New York 13219
Phone: (315) 475-7121
Fax: (315) 475-7144

PATIENT INFORMATION **EMAIL ADDRESS:**_____

First Name:	Last Name:	Middle Initial:	Date: / /
Address:	City:	State:	Zip:
Birth date: / /	Age:	☐ Male ☐ Female	
Home Phone: ( ) -	Alternative Phone (Cell, Pager): ( ) -	Spouse:	

Chose Clinic Because/ Referred to Clinic By ☐ Dr.: ☐ Insurance Plan ☐ Family ☐ Friend

☐ Former Patient ☐ Close to Work/Home ☐ Website ☐ Yellow Pages ☐ Street Sign ☐ Other:

WORK INFORMATION

Employer:	Work Phone ( ) -	Ext.
Occupation:	Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed	

CARE PROVIDER INFORMATION

Referring Dr:	Referring Dr. Phone: ( ) -
Regular Dr./PCP	Regular Dr./PCP Phone: ( ) -

INSURANCE INFORMATION **(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)**

Primary Insurance Name:	
Subscriber's Name (If different):	Birth date : / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:	
Name of Secondary Insurance:	
Subscriber's Name:	Birth date : / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:	

AUTO OR WORK INJURY CLAIM **(PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)**

Insurance Name: ☐ Auto :	☐ Labor & Industries:		
Adjuster/Claim Manager:	Phone:	Ext.:	
Address:	City	State:	Zip:
Claim #:	Accident Date: / /	Cause:	

ATTORNEY INFORMATION

Name:	Law Firm:	Phone: ( ) -	
Address	City	State:	Zip:

IN CASE OF EMERGENCY

Name of Local Friend or Relative:		
Relationship to Patient:	Home Phone: ( ) -	Work Phone: ( ) -

I authorize my insurance benefits be paid directly to Achieve Physical Therapy & Aquatic Therapy. I understand that I am financially responsible for any balance. I also authorize to Achieve Physical Therapy & Aquatic Therapy to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE DATE

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Medical History Form

Patient Name: _____ Height _____Weight: _____

Past/Present Medical Conditions (Check Yes or No)					
Asthma	☐ Yes	☐ No	Heart Attack	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Hernia	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Circulatory Disease	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Metal/Other Implant	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Multiple Sclerosis (MS)	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No	Nervous Disorder	☐ Yes	☐ No
Eating Disorder	☐ Yes	☐ No	Numbness	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Pregnancy	☐ Yes	☐ No
Fainting	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Headaches	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No
Fever/Chills/Sweats	☐ Yes	☐ No	Night Pain	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No	Nausea/Vomiting	☐ Yes	☐ No
Dysuria	☐ Yes	☐ No	Bowel Dysfunction	☐ Yes	☐ No
Urinary Frequency Changes	☐ Yes	☐ No	Unexplained Weight Change	☐ Yes	☐ No

Have you had any medical problems or hospitalizing in the past year? ☐ Yes ☐ No

If "yes", please specify: _____
_____

Surgical History: Procedure/Date: _____ Procedure/Date: _____

Medications Currently Taking:_____
_____

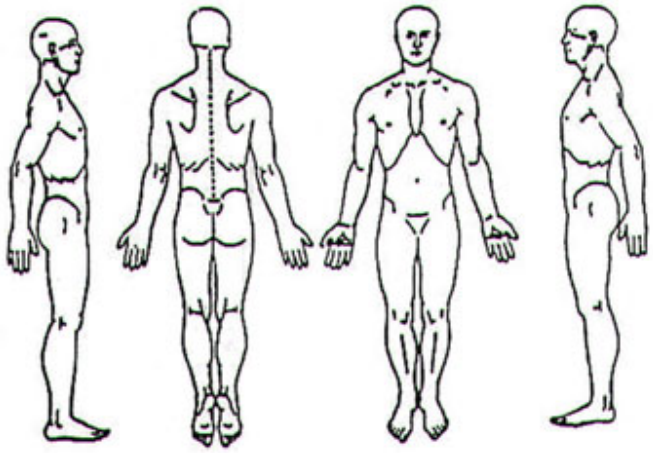
Exercise:	☐ None	☐ 1-2x/wk	☐ 3-4x/wk	☐ 5+ x/wk
Work Activity:	☐ Sitting	☐ Standing	☐ Light Labor	☐ Heavy Labor
Stress Level:	☐ Low	☐ Medium	☐ High	
Habits:	☐ Smoking	# Cigs per day:_____		
	☐ Alcohol	# Drinks per week:_____		
	☐ Coffee/Soda	# Cups per week:_____		

Have you had Physical Therapy before? ☐ Yes ☐ No

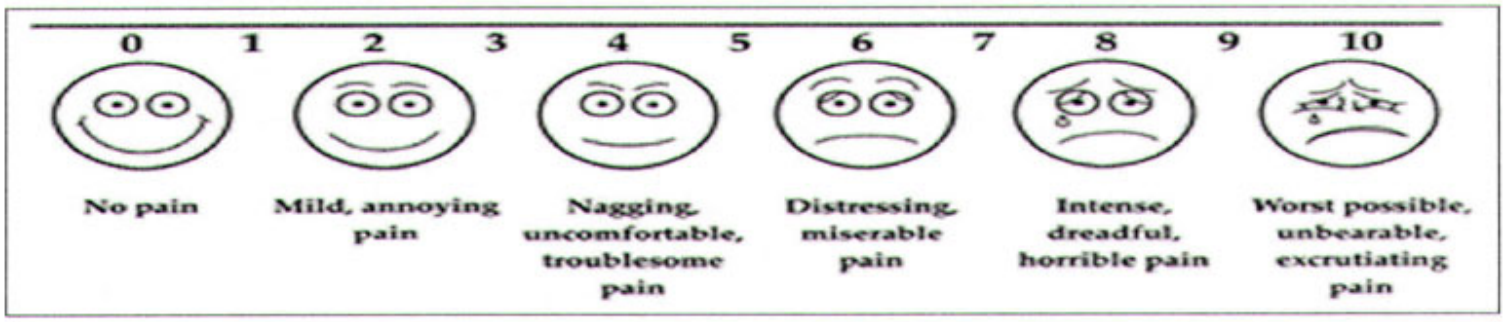
If "yes", when?_____

Achieve Physical Therapy
Medical History Form (Page 2)

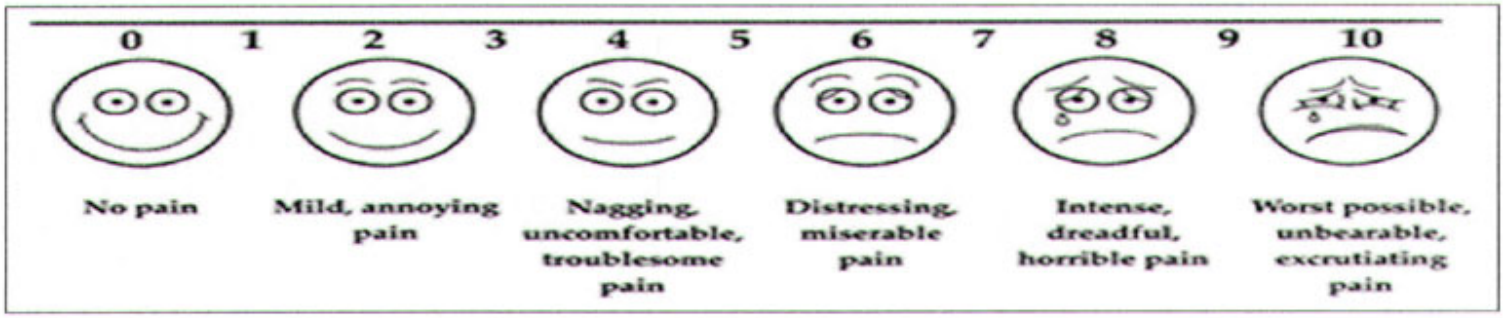
Please circle or shade where you are experiencing pain:



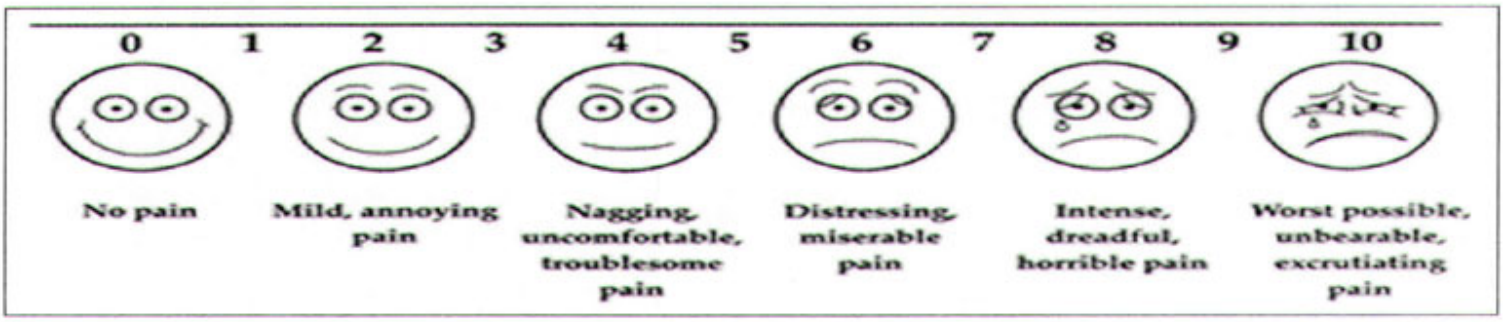
CURRENT Pain Level (circle one):



BEST Pain Level (circle one):



WORST Pain Level (circle one):



Patient Signature: _____ Date: _____

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General Request for Service, Release of Information, Personal Effects and Financial Authorization

I. I hereby voluntarily consent to such evaluation procedures and therapy and to such medical and diagnostic tests, as is necessary in the judgment of the Physical Therapist. I state that I have read and understand the following authorization and that I understand why the described treatment is necessary.

II. I hereby release Achieve Physical Therapy from all liability resulting from loss or damage to any personal effects retained by me on arrival or received by me. This includes, but not limited to, jewelry, eyeglasses, electrical devices, clothing, and any other personal item(s).

III. **A. Authorization for Release of Information by Achieve Physical Therapy**

I hereby authorize and direct the above names facility, having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my treatment and medical care, all information needed to substantiate payment for such treatment and medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

B. Assignment to Achieve Physical Therapy

I hereby irrevocably assign, transfer, and set over to the above named facility sufficient monies and/or benefit to which I may be entitled from governmental agencies, insurance carriers or others who are financially liable for my treatment and medical care to cover the costs of the care and treatment rendered to myself or my dependent in said facility.

C. Guarantee of Payment to Achieve Physical Therapy

I request Achieve Physical Therapy to furnish all services and treatments as may be recommended or directed by the patient's physician. I acknowledge receipt of the same, and I agree to pay charges therefore, based on rates in effect at your facility. I understand that services may not be covered under my insurance. I also understand that I may be liable for payment of services not covered under my insurance. ******NOTICE OF ADVISE****: **The notice of advice advises the patient that the treatment may not be covered by their specific health care plan or insurer without a referral. I understand that services may not be covered under my insurance. I also understand that I may be liable for payment of services not covered under my insurance and it is my responsibility to understand my physical therapy benefits, eligibility and coverage.**

_____
(Initials)

D. For Patients Entitled to Medicare Benefits

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for therapy services to Achieve Physical Therapy or authorize such entity or corporation to submit a claim to Medicare for payment to me.

_____
(Initials)

E. I have been provided with a copy of this document to retain for my future reference. _____
(Initials)

IV. I have been offered the HIPAA information as provided by Achieve Physical Therapy.
I have read the above certifications, or they have been read to me and I fully understand them.

Patient's Signature (Parent or Guardian if Minor) or Authorized Representative	Date/Time	Achieve Physical Therapy Representative

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POLICY ON SCHEDULED APPOINTMENTS

Dear Patient:

This is to inform you of Achieve Physical Therapy's policy regarding keeping scheduled appointments. Due to treatment schedule, you **must** notify us a minimum of 24 hours before your scheduled appointment if you are unable to attend your therapy session. **Should you fail to contact us, we reserve the right to personally bill you $50.00 for appointment(s) missed. This cannot/will not be billed to your insurance company**.

****PLEASE NOTE:** **If you are being treated under Workers' Compensation or No Fault, failure to attend Physical Therapy appointments may be viewed by the carrier as being non-compliant and could be considered grounds for a reduction in allowed benefits**.

We thank you for your cooperation in this manner.

Please sign below to confirm you have been informed of our policy.

_____

Patient's Signature

Date:_____

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I acknowledge that I have been given the opportunity to read/ or receive a copy of Achieve Physical Therapy's Privacy notice.

Person(s) authorized to receive/discuss my health information:

_____ _____

Name Relationship

_____ _____

Signature Date