NEW SCOTLAND
PHYSICAL THERAPY
Balance in Motion

Congratulations! You have taken the first steps towards your recovery and reaching a healthier you. We would like to welcome you to New Scotland Physical Therapy, LLC. Our goal is your complete wellbeing and recovery. By completing the following forms to the best of your ability we will better be able to understand your health condition and treat you appropriately.

Your visit today will consist of an evaluation from a licensed Physical Therapist. Based on your evaluation and the treatment plan prescribed by your physician, your therapist will establish a plan of care unique to you and your needs. Your treatments will involve a variety of techniques and exercises to assist you in achieving your goals and returning you to optimal function. These treatments on average will last between one half and one hour, but may vary depending on your condition.

We participate with several insurance companies and if appropriate we will bill your insurance company for our service. If your insurance plan requires a co-payment this is due at the time of service. Insurance plans vary and it is your responsibility to verify your insurance coverage.

In order to provide the best care possible in serving all of our patients we ask that you make every effort to make your scheduled appointments in a timely manner. We understand that circumstances occur and you may need to change an appointment. We ask that you make every effort to notify us within **24 hours** of your scheduled appointment. We will work with you within your circumstances, but please note no-shows and cancellations may be subject to a $25.00 charge. Your consideration is greatly appreciated as it helps us better serve **all** of our patients.

We look forward to working with you and are so happy you have chosen New Scotland Physical Therapy to help you reach your health and fitness goals.

Please fill out the following information thoroughly so that we have all the information we need to best help you. Feel free to ask any questions.

Patient Information

Full Name: _______________________________ Date of Birth: ___ - ___ - ______Today's date: ____________________

Address: _____________________________________ City: ___________________ State: ________ Zip: ___________

Home Phone: (___) _________________ Cell Phone: (___) ______________ Work Phone: (___) ___________________

Gender: *M or F* Marital Status: *S M D W* Height: ______ Weight: _______ Age: _______ SS#: __________________

Occupation: ___________________________ Employer:_______________________ __________

Spouse's /Partner's Name:__________________ Work Phone: (___) ____________ Cell Phone: (___) ________________

Emergency Contact: _______________________ Relationship: _________________ Phone: (____) __________________

Email: __________________@____________________ Would you like to receive our monthly newsletters? *Yes* *No*

How did you hear about us?

Insurance Information

Primary insurance: __________________________ ID# _______________________ Group # _____________________

Name of insured: ____________________________ Relationship to insured : _______________________________

Secondary insurance : _____________________ ID# _______________________ Group # ____________________

Name of insured : ___________________________ Relationship to insured : __________________________________

If No Fault, name of No-fault Insurance Company: ____

Insurance Company Address : ____

Date of Accident: ____________________ Claim # _______________________ Policy # _________________________

If Worker's Compensation, Worker's Compensation Insurance Carrier: ____

Employer at the time of injury: _______________________________ Date of injury: ____________________________

Last day of work: ________________________ Carrier address: ____

Case manager : _______________________________________ Phone number:_________________________________

Carrier case # : ____ WCB# : ______________________________________

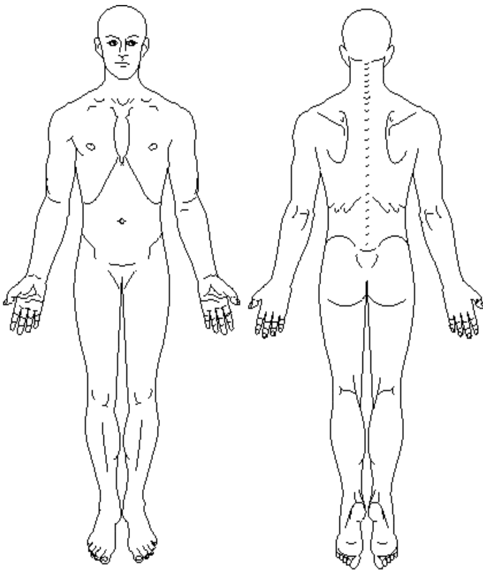
Purpose of this Visit

Diagnosis/What brought you in today? ____

Referring Physician ________________________ Date of Onset_______________ Date of Surgery_______________

Does this condition interfere with: ___ *Work* ___ *Sleep* ___ *Family* ___ *Hobbies* ___ *Daily Routine* ___ *Mood* ___ *Social*
Explain____

Have you had any prior treatment for this condition? *Yes No* Explain____
How did your body respond? ____



Please use the drawing to the left to indicate where your current pain is. Using the following symbols, please indicate the type of pain:

Sharp Pain //// Achiness XXXX

Burning ✓✓✓ Pins/Needles !!!!

Numbness ++++

If 10 is the worst pain imaginable, and 0 is no pain, please indicate your pain:
Over the last two weeks :____/10__ Today: ____/10_ Radiating pain: Yes/No, If yes where _________________

What makes your pain BETTER? ____

What makes your pain WORSE? ____

Would you describe your pain as: Constant ___Frequent ___Occasional ___Seldom ___Other________________

Pain Quality: How would you describe your pain/discomfort (Check all that apply):
Dull ___Achy ___Throbbing ___Stiff ___Burning___ Sharp __Stabbing ___Shooting ___Intense___ Constricting ___
Other: ____

Medical History

Have you or any immediate family member ever been told you have:

	Self		Family	
Cancer	Yes	No	Yes	No
High Blood Pressure	Yes	No	Yes	No
Diabetes	Yes	No	Yes	No
Heart Disease	Yes	No	Yes	No
Angina / Chest Pain	Yes	No	Yes	No
Stroke	Yes	No	Yes	No
Arthritis	Yes	No	Yes	No
Osteoporosis	Yes	No	Yes	No

Do you have a history of:

Shortness of Breath	Yes	No
Allergies	Yes	No
Asthma	Yes	No
Metal Implants	Yes	No
Polio	Yes	No
Emphysema	Yes	No
Do you smoke?	Yes	No
Are you Pregnant?	Yes	No

Have you had or do you experience: (If answered yes, please explain briefly with approximate dates)

Surgery	Yes	No	______________________________
Nausea / vomiting	Yes	No	______________________________
Fever / chills / sweats	Yes	No	______________________________
Unexplained weight change	Yes	No	______________________________
Numbness or tingling	Yes	No	______________________________
Muscular weakness	Yes	No	______________________________
Fainting spells	Yes	No	______________________________
Dizziness	Yes	No	______________________________
Night pain	Yes	No	______________________________
Bowel or bladder changes	Yes	No	______________________________
Headaches	Yes	No	______________________________

Please List current medications:

____

____

____

List the results of any diagnostic tests (i.e., X-rays, MRI, Bone scans, EMG, etc.): ___________

____

Patient Consent and Guarantee

*****IMPORTANT: PLEASE READ THIS CAREFULLY*****

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize that the payment of authorized benefits be made directly to New Scotland Physical Therapy, LLC for any services that are reimbursable by Medicare, Medicaid, or any third party sources.

VALUABLES

I hereby understand that New Scotland Physical Therapy, LLC is not responsible for valuables or personal property brought to the facility.

CONSENT OF TREATMENT

I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while I am a patient of New Scotland Physical Therapy, LLC.

GUARANTEE OF ACCOUNT

In consideration of services rendered to me by New Scotland Physical Therapy, LLC, I hereby guarantee payment for any and all services rendered to me in which are not covered or allowable by insurance, together with collection costs, including reasonable attorney fees. I understand that there may be a charge for supplies that are needed during my course of treatment that will not be covered by my insurance and for which I am financially responsible. I also understand that I may have a co-payment, co-insurance and/or deductible for which I am fully responsible for paying. Although New Scotland Physical Therapy, LLC will inform me of my insurance coverage for physical therapy, **it is ultimately my responsibility to understand my insurance benefit limitations and payments**. I will immediately notify New Scotland Physical Therapy, LLC of changes in my insurance coverage while receiving physical therapy.

MEDICARE

I hereby 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 or its intermediaries or carriers any such information needed for this or a related Medicare Claim. I request that the payment of authorized benefits be made on my behalf. I understand that I am responsible for any health insurance deductibles and co-insurance.

I, ______________________, by signing this document, acknowledge my consent to the above:
(Print Name)

Signature: ___________________________ Date: ________________

Notice of Protected Health Information Practices

This notice describes how Medical Information about you may be used and disclosed and how you can get access to this information.

PLEASE REVIEW IT CAREFULLY.

Purpose of Notice

Under the federal health care privacy regulations pertaining to the Health Insurance Portability and Accountability Act of 1996 set forth at 45 CFR § 160.101 et seq. (the "Privacy Regulations"), Excel Physical Therapy ("the Practice") is required to protect the privacy of your individually identifiable health information, which includes information about your health history, symptoms, test results, diagnoses, treatment, and claims and payment history. We are also required to provide you with this Notice of Protected Health Information Practices regarding our legal duties, policies and procedures to protect and maintain the privacy of your health information ("the Notice"). We will not use or disclose your health information except as provided for in this Notice. However, we reserve the right to change the terms of this Notice and make new notice provisions for all your health information that we maintain.

Permitted Uses and Disclosures of Your Health Information

1. Uses and Disclosures with Patient Consent: Under the Privacy Regulations, after having made good faith efforts to obtain your acknowledgement of receipt of this Notice, we are permitted to use and disclose your health information for the following purposes:

a. **Treatment**. We are permitted to use your health information in the provision and coordination of your health care. We may disclose information contained in your medical record to your primary health care provider, consulting providers, and to other health care personnel who have a need for such information for your care and treatment. For example, your physical therapist may disclose your health information when consulting with a physician regarding your medical condition.

b. **Payment**. We are permitted to use your health information for the purposes of determining coverage, billing, claims management, medical data processing and reimbursement. This information may be released to an insurance company, third party payor or other authorized entities involved in the payment of your medical bill and may include copies or portions of your medical record which are necessary for payment of your account. For example, a bill sent to your insurance company may include information that identifies you, your diagnosis, and the procedures and supplies used in your treatment.

c. **Health Care Operations**. We are permitted to use and disclose your health information during the Practice's routine health care operations, including, but not limited to, quality assurance, utilization reviews, medical reviews, auditing, accreditation, certification, licensing or credentialing activities and for education purposes.

2. **Uses and Disclosures With Patient Authorization**. Under the Privacy Regulations, we can use and disclose your health information for purposes other than treatment, payment or health care operations with your written authorization. For example, with your authorization we can provide your name and medical condition to companies who might be able to provide you useful items or services. Under the Privacy Regulations, you may revoke your authorization; however, such revocation will not have any effect on uses or disclosures of your health information prior to our receipt of the revocation.

3. **Uses and Disclosures With Patient Opportunity to Verbally Agree or Object**. Under the Privacy Regulations, we are permitted to disclose your health information without your written consent or authorization to a family member, a close personal friend or any other person identified by you, if the information is directly relevant to that person's involvement in your care or treatment. You must be notified in advance of the use or disclosure and have the opportunity to verbally agree or object.

4. **Uses and Disclosures Without an Acknowledgement, Authorization or Opportunity to Verbally Agree or Object.** Under the Privacy Regulations, we are permitted to use or disclose your health information without your consent, authorization or the opportunity to verbally agree or object with regard to the following:

a. **Uses and Disclosures Required by Law**. We will disclose your health information when required to do so by law.

b. **Public Health Activities**. We may disclose your health information for public health reporting, reporting of communicable diseases and vital statistics and similar other circumstances.

c. **Abuse and Neglect**. We may disclose your health information if we have a reasonable belief of abuse, neglect or domestic violence.

d. **Regulatory Agencies**. We may disclose your health information to a health care oversight agency for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations and inspections. These activities are necessary for the government and certain private health oversight agencies to monitor the health care system, government programs and compliance with civil rights.

e. **Judicial and Administrative Proceedings**. We may disclose health information in judicial and administrative proceedings, as well as in response to an order of a court, administrative tribunal, or in response to a subpoena, summons, warrant, discovery request or similar legal request.

f. **Law Enforcement Purposes**. We may disclose your health information to law enforcement officials when required to do so by law.

g. **Coroners, Medical Examiners, Funeral Directors**. We may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your health information to funeral directors, as necessary, to carry out their duties.

h. **Research.** Under certain circumstances, we may disclose your health information to researchers when their clinical research study has been approved by an institutional review board that has reviewed the research proposal and provided that certain safeguards are in place to ensure the privacy and protection of your health information.

i. **Threats to Health and Safety**. We may use or disclose your health information if we believe, in good faith, the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.

j. **Military/Veterans**. If you are a member of the armed forces, we may disclose your health information as required by military command authorities.

k. **Workers' Compensation**. We may disclose your health information to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

l. **Marketing**. We may use or disclose your health information to make a marketing communication to you, if such communication is conducted face-to-face, concerns products or services of nominal value, or identifies us as the communicating party and that we will receive remuneration for making the communication and, where required by the Privacy Regulations, instructions describing how you may verbally object to receiving future communications.

m. **Appointment Reminders**. We may use and disclose your health information to remind you of an appointment for treatment and medical care at our practice.

n. **Other Uses and Disclosures**. In addition to the reasons outlined above, we may use and disclose your health information for other purposes permitted by the Privacy Regulations.

5. **Uses and Disclosures to Business Associates**. With an acknowledgement or a proper authorization, we are permitted to disclose your health information to Business Associates and to allow Business Associates to receive your health information on our behalf. A Business Associate is defined under the Privacy Regulations as an individual or entity under contract with us to perform or assist us in a function or activity which requires the use of your health information. Examples of business associates include, but are not limited to, consultants, accountants, lawyers, medical transcriptionists and third party billing companies. We require all Business Associates to protect the confidentiality of your health information.

Patient Rights

Although your medical record is our property, you have the following rights concerning your medical record and health information:

1. **Right to Request Restrictions on the Use and Disclosure of Your Health Information**. You have the right to request restrictions on the use and disclosure of your health information for treatment, payment and health care operations. However, we are not required to agree with such a request. If, however, we agree to the requested restriction, it is binding on us.
2. **Right to Inspect and Copy Your Health Information**. You have the right to inspect and copy your own health information upon request. However, we are not required to provide you access to all the health information that we maintain. For example, this right does not extend to psychotherapy notes, information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative proceeding, or subject to or exempt from Clinical Laboratory Improvements Amendments of 1988. Access may also be denied if disclosure would reasonably endanger you or another person.
3. **Right to Verbally Object**. You have the right to verbally object to certain disclosures that are routinely made for treatment, payment or healthcare operations or for other purposes without an Authorization. For example, we are required to give you an opportunity to object to the sharing of your health information with a person or family member accompanying you for treatment.
4. **Right to Seek an Amendment of Your Health Information**. You have the right to request an amendment of your health information. If we disagree with the requested amendment, we will permit you to include a statement in the record. Moreover, we will provide you with a written explanation of the reasons for the denial and the procedures for filing appropriate complaints and appeals.
5. **Right to an Accounting of Disclosure of Your Health information**. You have the right to receive an accounting of disclosures made by us of your health information within six (6) years prior to the date of your request; provided, however that we need not provide an accounting for any information disclosed prior to April 14, 2003. The accounting will not include disclosures related to treatment, payment or health care operations, disclosures made to you, disclosures made pursuant to a validly executed authorization, disclosures permitted by the Privacy Regulations, disclosures to persons involved in your care, or disclosures that occurred prior to the April 14, 2003 compliance deadline under the Privacy Regulations. The accounting of disclosures shall include the date of each disclosure, name and address of the person or organization who received your health information, a brief description of the information disclosed, and the purpose for the disclosure.
6. **Right to Confidential Communications**. You have the right to receive confidential communications of your health information by alternative means or alternative locations. For example, you may request that we only contact you at work or by mail.
7. **Right to Revoke Your Authorization**. You have the right to revoke a validly executed authorization for the use or disclosure of your health information. However, such revocation will not have any effect on uses or disclosures prior to the receipt of the revocation.
8. **Right to Receive Copy of this Notice**. You have the right to receive a copy of this Notice.

Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by New Scotland Physical Therapy (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.

2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.

3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: 1969 New Scotland Rd #8 Slingerlands, NY 12159

4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions):

____

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

______________________________ ______________________________

Signature of Patient or Representative Date

____

Patient's Name

____

Date of Birth

____

Social Security Number

______________________________ ______________________________

Name of Personal Representative (if applicable) Relationship to Patient