PT PLUS
DANCE, ORTHOPEDIC & SPORTS PHYSICAL THERAPY
130 West 56th Street, Suite 6M, New York, NY 10019
T 212.246.3700 F 212.246.3701

DIAGNOSIS CODES
(For office use only)
1. _____
2. _____
3. _____
4.

New Patient Registration Information:

Patient Name: _____ Today's Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone (Day): _____ Phone (Eve): _____ Phone (Cell): _____

May We Leave Messages at the Numbers Listed Above When We Need to Contact You? Yes / No

Email Address: _____

Employer Name & Address: _____

Date of Birth: _____ / _____ / _____ Social Security Number: _____ / _____ / _____

Name of Person We Should Contact in Case of Emergency: _____
Phone Number and Relationship: _____

Referring physician: _____ Date of follow-up with referring physician: _____

How did you find out about PT Plus, P.C.? _____

Primary Insurance Coverage:

Name of Policy Holder: _____ Date of Birth of Policy Holder: _____ / _____ / _____

Insurance Company: _____ Name as it Appears on Card: _____

Policy #: _____ Group #: _____ Ins Co. Phone #: _____

Insurance Co. Address: _____

Is Policy Holder the Guarantor? Yes / No ***If no***, name & address of person to be billed: _____

Release:
I hereby authorize PT Plus, P.C., to release medical information in accordance with federal privacy laws necessary to process this claim and request payment of benefits to the party who accepts assignment.

Signature of Patient or Guardian: _____ **Date:** _____

Consent for Treatment:
My signature below authorizes PT Plus, P.C., and its physical therapy staff to evaluate me and provide treatment for me in keeping with the diagnosis of the referring physician.

It is my understanding that my therapist will explain his or her findings to me as well as his or her plan of treatment.

I understand that I may ask questions of my therapist at any time and that I may elect not to participate in a recommended treatment or exercise at my sole discretion.

Signature of Patient or Guardian: _____ **Date**: _____

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PATIENT POLICIES

Referral / Prescriptions

New York State law requires that you must have a current prescription for physical therapy from a New York State licensed physician or nurse practitioner.

Lockers

We are a small facility and, as such, are unable to permit you to leave your belongings in a locker overnight. Kindly plan your visit so that you are able to transport your belongings on a daily basis.

Showers

Showers available for your use on every non-"M" floor of this building. The shower areas are unisex as designated by the signs outside each shower area. PT Plus will provide you with towels for your convenience.

Lateness

We schedule in such a way as to permit optimal time for your treatment. Accomplishing optimal intervention, however, requires that you arrive on time for your appointment. Your promptness will be greatly appreciated. If you arrive late, you will be billed for a full treatment session, but your treatment time will be adjusted accordingly. With the interest of giving you the best attention possible, we may refuse you treatment if we determine that the time remaining for your appointment is not sufficient to render beneficial care. In that event, you will incur a cancellation fee equivalent to that of the scheduled appointment.

Cancellations

If you are unable to keep a scheduled appointment, we ask that you kindly give us 24 hours notice. Calling 24 hours in advance allows us to place another person waiting to be seen in your time slot. If you learn that you must cancel after our business hours, kindly leave a message on our voice mail system. Failure to cancel with 24 hours advance notice will result in a fee equivalent to that of the scheduled appointment charged to your credit card.

No Show

Patients who "no-show" will incur a fee equivalent to that of the scheduled appointment charged on their credit card for each "no-show" and will also be discharged from our care after three offenses.

Payment

All payments (to include balances due and cancellation/no-show fees) are expected before each daily session and may be made by credit card only. Our policy requires that you check in with our front desk personnel each and every treatment day to settle your account *before* entering the treatment area.

Signature

By signing below, I certify that I have read the above policies, understand them and will comply with them. I agree with PT Plus that it retains the right to charge my credit card for scheduled appointments missed by lateness, late cancellation or no-show activity, as described above.

Signature of Patient or Guardian: _____ **Date**: _____

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Payment Policy

Please read carefully the information in the checked area below and sign at the bottom of the page to indicate your full awareness of our payment policies and of your insurance benefits as they pertain to the physical therapy charges you will incur at our facility.

Your signature below indicates your agreement with PT Plus, P.C., that it is not responsible for any benefit discrepancies with your insurance carrier before, during or after the time of your care, and/or for any errors related to the verification of your benefits. You are encouraged to check directly with your carrier about verification of your benefits.

☐ **Direct Payment**

My signature below indicates that I understand payment in full will be expected of me at the time of each treatment session.

PT Plus, P.C., accepts Mastercard, Visa and American Express as methods of payment. For my records and convenience, PT Plus, P.C., will give a receipt to me at the time of each payment. Receipts for payment will contain all the necessary and pertinent insurance coding information required for reimbursement by my insurance carrier. PT Plus, P.C., offers courtesy billing to some commercial insurance companies. I fully understand it is ultimately my responsibility to secure reimbursement from my insurance carrier for the physical therapy care that I receive.

By signing below, I understand that an imprint of my credit card is required on the date of my initial visit for the purpose of guaranteeing scheduled appointments against late cancellations and no-shows.

☐ **Assignment to PT Plus, P.C. (Workers' Compensation patients only)**

I certify that I have an open Worker's Compensation case, and hereby assign the benefits to cover the costs of my physical therapy care to PT Plus, P.C.. I agree to pay PT Plus, P.C., for all reimbursement monies sent to me by the insurance carrier for physical therapy services.

By signing below, I understand that an imprint of my credit card is required on the date of my initial visit for the purpose of guaranteeing scheduled appointments against late cancellations and no-shows and for the purpose of balance billing any charges not covered by my insurance carrier.

☐ **Contracted Company Direct Payment**

I certify that I have officially confirmed my eligibility for physical therapy care through my employer and that they have guaranteed full payment to PT Plus, P.C., for the treatment I receive.

By signing below, I understand that an imprint of my credit card is required on the date of my initial visit for the purpose of guaranteeing scheduled appointments against late cancellations and no shows and for the purpose of paying any balance not covered by my employer.

Signature of Patient or Guardian: _____ **Date**: _____

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CREDIT CARD INFORMATION SHEET

PATIENT NAME: _____

TYPE OF CREDIT CARD: VISA / MASTERCARD / AMEX

NAME (EXACTLY) ON CREDIT CARD: _____

CARD NUMBER: _____

SECURITY CODE: _____

EXPIRATION DATE: _____

ADDRESS WHERE CARD INVOICE IS SENT MONTHLY:

NAME: _____

STREET: _____

CITY:_____STATE: _____ZIP:_____

SIGNATURE: _____

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Medical History

Name _____

1. Sex ☐Male ☐Female

2. Height _____ **Weight** _____

3. Are you ☐Right-handed ☐Left-handed

4. Cultural/Religious

Any customs or religious beliefs or wishes that might affect care? _____

6. Occupation _____

8. General Health Status

Please rate your health:

☐Excellent ☐Good ☐Fair ☐Poor

Have you had any major life changes during past the year? (e.g., new baby, job change, death in family)

☐Yes ☐No If yes, what? _____

Are you pregnant, or think you might be pregnant? ☐ Yes ☐ No

5. Current Condition(s)/Chief Complaint(s)

Describe the problem(s) for which you seek our fitness and wellness services.

_____
_____
_____
_____
_____

When did the problem(s) begin (date)? _____/_____/_____
What happened? _____
_____
_____

Have you ever had the problem(s) before? ☐Yes ☐No
What did you do for the problem(s)? _____
_____

Did the problem(s) get better? ☐Yes ☐No

Are you seeing anyone else for the problem(s)?
If so who? _____

9. Social/Health Habits

Smoking:

Currently smoke tobacco? ☐ Yes ☐ No
☐ Cigarettes, # of packs per day _____
☐ Cigars/Pipes, # per day _____

Alcohol:

On average, how many days per week do you drink beer, wine, or other alcoholic beverages? _____

If one beer, one glass of wine, or one cocktail equals one drink, how many drinks do you have on an average day? _____

Exercise:

Exercise beyond normal daily activities and chores?
☐ Yes ☐ No
Describe the exercise: _____
_____

On average, how many days per week do you exercise or are you physically active? _____

How many minutes on an average day? _____

11. Medical/Surgical History

Please check if you have ever had:

☐ Allergies
☐ Arthritis
☐ Blood disorders
☐ Broken bones/ fractures
☐ Cancer
☐ Circulation/vascular problems
☐ Developmental/growth problems
☐ Repeated infections
☐ Diabetes/high blood sugar
☐ Head injury
☐ Heart problems
☐ High blood pressure
☐ Infectious disease (such as tuberculosis, hepatitis)
☐ Chest pain
☐ Loss of balance
☐ Dizziness or blackouts
☐ Heart palpitations
☐ Other _____

☐ Low blood sugar/ hypoglycemia
☐ Lung problems
☐ Multiple sclerosis
☐ Muscular dystrophy
☐ Osteoporosis problems
☐ Parkinson's disease
☐ Seizures/epilepsy
☐ Skin diseases
☐ Stroke
☐ Thyroid problems
☐ Ulcers/stomach problems
☐ Kidney problems
☐ Joint pain or swelling
☐ Pain at night
☐ Headaches

Have you ever had surgery? ☐ Yes ☐ No
If yes, please describe and include dates:
Date: _____ Description: _____
Date: _____ Description: _____
Date: _____ Description: _____

12. Medications

Do you take any prescription or nonprescription medications?
☐ Yes ☐ No
If yes, please list:_____
_____

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