Physical Solutions LLP
60 East Jericho Turnpike
Mineola, New York 11501

516.746.6350
516.746.6696 fax

Physical Solutions LLP
1211 Stewart Avenue
Bethpage, New York 11714

516.576.5751
516.576.5755 fax

Edward B. Farrell, MS, PT, OCS, CSCS
Christopher R. Lopez, MS, PT, OCS, CSCS

email: frontdesk@physicalsolutionsli.com
www.physicalsolutionsli.com

Physical Solutions™

General Information

Patient Name (Last, First, MI) **Date of Birth**

Social Security Number:

Home Address

Home Phone Number **E-Mail** **Work/Cell Number**

Emergency Contact **Phone Number** **Relationship**

Office Policies and Procedures

You must sign in with the receptionist at the front desk.

All co-payments are due before each session. THERE WILL BE A $15.00 SURCHARGE APPLIED TO ALL LATE PAYMENTS.

Be aware of and keep your appointment time. If you should arrive early/late, you will be asked to wait/reschedule. Physical Solutions reserves the right to charge $15.00 for all appointments missed with less than 24 hours notice.

Cell phone use is STRICTLY PROHIBITED in all treatment areas; this includes text messaging.

Your physical therapist will remain in contact with your referring physician/surgeon through written evaluation/progress reports, as well as phone calls when necessary. Physical Solutions LLP will be happy to forward copies of all written correspondence to your primary care physician as well; by signing and filling out the information below, you hereby give Physical Solutions LLP permission to do so.

Patient Signature_____

Primary Care Physician's Name: _____
Telephone: _____
Fax: _____
Address: _____
_____
_____

Consent for Care and Treatment
I, the undersigned, do hereby agree and give consent to Physical Solutions LLP to furnish medical care and treatment to (patient) _____ that is considered necessary in diagnosing or treating my/his/her condition.

Notice of Privacy Practices
As per HIPAA guidelines, I acknowledge that I have read and understand the Notice of Privacy Practices for Physical Solutions LLP and may be furnished with a copy upon my request.

Benefit Assignment
I hereby assign medical benefits to which I am entitled, including Medicare, private insurance, and third party payors, to Physical Solutions LLP. A photocopy of this assignment is to be considered as valid as the original.

Financial Policy Statement
If any payment is made directly to me for services billed by Physical Solutions LLP, I recognize an obligation to promptly remit that amount along with any explanation of payment to Physical Solutions LLP. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed including original charges, interest, collection agency fees and attorney fees.

Billing and Benefits
It is the patient's responsibility to maintain all prescriptions, referrals, and authorizations as required by your insurance company. We will bill your insurance carrier as a courtesy to you. We have called your insurance carrier for estimated insurance benefits, and they are as follows:

PATIENT RESPONSIBILITY _____

PAYMENT FROM YOUR INSURANCE COMPANY _____

TOTAL PAYMENT TO PHYSICAL SOLUTIONS _____

Estimated coverage information is provided as a courtesy to our patients and is not intended to release them from total responsibility of treatment. Actual plan benefits can only be determined upon receipt and processing of your claims (Federal Regulation Code 29 Section 2560.503-1).

Worker's Compensation Clause
The above does not apply for those patients that are considered Worker's Compensation. However, be advised if you claim Worker's Compensation benefits and are subsequently denied, you will be held responsible for any remaining balance on your account. At that time, our Financial Policy will apply to you.

I have read all of the preceding information and understand my responsibilities.

_____
Patient's Name (please print)

_____
Patient/Guardian Signature

_____
Physical Solutions LLP Employee Signature

Medical History

Name: _____ Age: _____ Date of Birth: _____

Describe your current complain: _____

_____ Height: _____ Weight: _____

When did your condition begin? _____ How did your problem begin? _____

_____

Have you had this problem in the past? Yes or No

Have you been treated for this same problem in the past? Yes or No

If yes, please describe: _____

Have you had surgery? Yes or No Surgery date: _____

Have you had other surgeries to the same area in the past? Yes or No

If yes, please describe: _____

Current level of pain (0 = no pain, 10 = require emergency room care):

At rest: 1 2 3 4 5 6 7 8 9 10

With Movement: 1 2 3 4 5 6 7 8 9 10

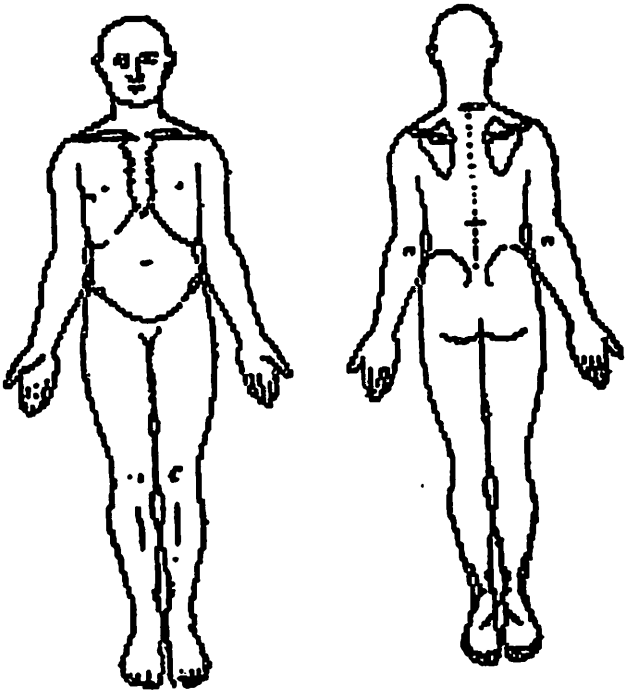
Since your condition began have your symptoms: decreased not changed increased

What makes your problem better? _____

What makes your problem worse? _____

What percentage of the time are your symptoms present? 0% 25% 50% 75% 100%

Please mark on the drawings below, where you feel your pain.



Please check any of the following services that you have received for this condition:

___ Orthopedist	___ Physical therapy	___ X-rays	___ EMG
___ Chiropractor	___ Occupational Therapy	___ CT Scan	___ NCV
___ Neurologist	___ Massage Therapy	___ MRI	___ Injection
___ General Practitioner	___ Myelogram	___ Cast or Brace	
___ Emergency room care	___ other: _____		

Have you had other treatment for this ***current*** condition: Yes or No

If yes, please describe: _____

Please list any medications you are currently taking: _____

_____

Please check any of the following that are in you health history:

__ Asthma
__ Shortness of Breath
__ Coronary Heart Disease
__ Chest Pain
__ Pacemaker
__ High Blood Pressure
__ Heart Attack
__ Heart Surgery
__ Stroke or TIA
__ Blood clot or Emboli
__ Epilepsy or Seizures
__ Thyroid Trouble or Goiter
__ Sleeping Problems
__ Emotional or Psychological
__ Headaches
__ Numbness or Tingling
__ Dizziness or fainting
__ Blurred Vision
__ Ringing in the Ears
__ Weakness
__ Weight loss
__ Night sweats
__ Hernia
__ Varicose Veins
__ Allergies
__ Anemia
__ Infectious Disease
__ Neurological Problems
__ Diabetes
__ Metal Implants
__ Cancer
__ Smoking
__ Arthritis or swollen joints
__ Are you Pregnant?
__ Osteoporosis

Please list any past surgeries: _____
_____
_____

Please list any past hospitalizations: _____
_____
_____

Please list three goals you would like to achieve while in physical therapy:

1. _____
2. _____
3. _____

Patient/Guardian Signature: X _____ Date: _____