

MEDICAL HISTORY

Name: _____ Age: _____ DOB: _____

Type of cancer: _____ Date of diagnosis: _____

Oncologist: _____ Radiation Oncologist: _____

Specific Location: (Left/Right Breast) _____

Presenting Symptoms (symptoms that led to the diagnosis: fatigue, nausea, etc.) _____

Cancer surgery (yes or no)? _____

Type of surgery: _____

Date(s) of surgery: _____

Surgeon's name: _____

Post surgery treatment: (chemotherapy or radiation) _____

Length of treatment: _____

Date of final treatment or still in treatment? _____

Complications?: _____

Medications for cancer or cancer complications: _____

Other medications: _____

Describe your current complaints: _____

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

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

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

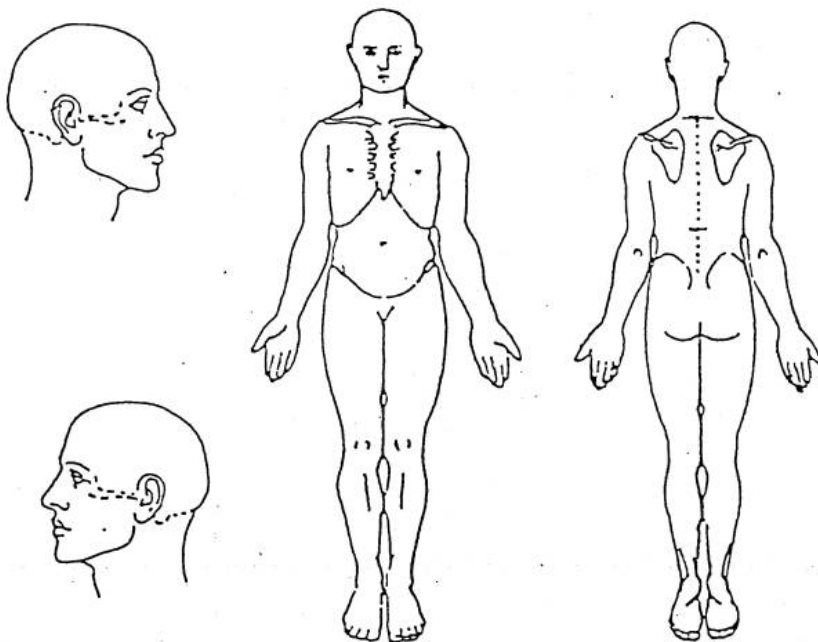
Since your condition began, have your symptoms: decreased not changed increased

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:



PT INITIALS: _____

Name: _____ Age: _____ DOB: _____

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

- | | | |
|--|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Emotional/Psychological | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Infectious Disease |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Neurological Problems |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Dizziness or fainting | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Metal Implants |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Ringing in the Ears | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Weakness | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Stroke or TIA | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Arthritis/swollen joints |
| <input type="checkbox"/> Blood clot or emboli | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Are you Pregnant? |
| <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hernia | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Thyroid trouble or Goiter | <input type="checkbox"/> Varicose Veins | |

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: _____ Date: _____

I have read and reviewed the medical history of _____.

Physical Therapist Signature

Date

OFFICE USE ONLY:

FINANCIAL POLICY STATEMENT

Southern Nassau Physical Therapy, Western Nassau Physical Therapy and Seaside Physical Therapy/DBA Peak Performance Physical Therapy will bill your insurance carrier as a courtesy to you. Patient responsibility is explained to you and co-payments or other payments responsibilities are due at each visit. Coinsurance and other payments will be billed to you after we receive payment from your insurance company.

It is your responsibility to inform the front desk of any policy changes in your insurance immediately. Many of the insurances require prior authorization for physical therapy. In the event of a policy change it may be required to obtain prior authorization. This is one of the very important reasons for immediate notification of policy change. In the event your insurance company requests a refund for payments made, you are responsible for the amount of money refunded by insurance company. In the event your insurance company reimburses payment directly to your home, payment must be signed over to Peak Performance Physical Therapy. Estimated coverage information is provided to you as a courtesy. It is not intended to release you from any patient responsibilities. We recommend checking your own benefits with your insurance company.

Workers Compensation and No Fault patients: if your case is closed or coverage is no longer effective it is your responsibility to submit a copy of your commercial insurance card to the front desk or the billing department. Check with the front desk or billing department to see if Peak Performance is a participating provider. If you do not have other medical coverage you are responsible for payment of your bills.

In the event payments requested from our office are not received in a timely fashion your account will be forwarded to our collection agency.

CANCELLATION POLICY

This is to notify you that we will charge you a \$15 fee, \$20 for aquatic therapy for all appointments missed within less than a 24 hour notice. Our office does acknowledge extenuating circumstances and will take into consideration when charging the fee.

Signature of patient or patients representative

Date

If this form is signed by the patient's representative, please complete the following:

Print the name of the Patient's Representative: _____

44 Broadway
Lynbrook, NY 11563
516-599-8734

3961 Long Beach Rd.
Island Park, NY 11558
516-897-9700

1730 Lakeville Road
New Hyde Park, NY 11040
516-326-4580

Patient Consent

1. I, understand, do hereby agree and give my consent for Peak Performance Physical Therapy to furnish me with medical care and treatment that is considered necessary and proper in diagnosing and/or treating my physical condition.

2. I acknowledge that I have been given a copy of the Notice of Privacy Practices, which describes the Practice's obligation to ensure the privacy of my health information. This HIPAA Privacy Notice also describes how the Practice may use and disclose my health information for treatment, payment and health care operations. I know that I have the right to review the Practice's HIPAA Privacy Notice and to ask for clarification of it. I understand that the Practice is required to maintain the privacy of my health information in accordance with the terms of the HIPAA Privacy Notice.

3. By signing this form, I consent to the Practice's use and disclosure of my health information for treatment, payment and health care operations. I understand that I have the right to revoke this consent at anytime in writing, but if I do, my revocation will not have an effect on any actions the Practice has already taken in reliance on this consent

4. I hereby assign all medical and/or surgical benefits to include medical benefits, to which I am entitled, including Medicare, private insurance and third party payers to Peak Performance Physical Therapy.

Signature of patient or patients representative

Date

If this form is signed by the patient's representative, please complete the following:

Print the name of the Patient's Representative: _____

Describe the representative's authority to act for the patient: _____

***NOTE: YOU MAY REFUSE TO SIGN THIS COSENT.
HOWEVER IF YOU DO REFUSE, THE PRACTICE MAY REFUSE
TO PROVIDE YOU WITH NON-EMERGENCY CARE.**

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