Riverdale Sports Physical Therapy

531 W 235th ST
Bronx, NY 10463
718-432-1323

Patient Intake Information INN

Name:

Sex: Male / Female Date of Birth:

Address:

Home Phone Number: Cell Phone Number:

Email Address:

Emergency Contact Name: Relationship:

Emergency Contact Phone:

Primary Insurance

Secondary Insurance

Doctor's Name?

Your Place of Employment? How did you hear about us?

I certify that the above information is complete and accurate.

Patient/Guardian Signature: Date

Confidential Health History

Please check all symptoms you currently have or had in the past year.

GENERAL

☐ Fever
☐ Chills
☐ Sweats
☐ Headache
☐ Dizziness
☐ Fainting
☐ Forgetfulness
☐ Depression
☐ Loss of sleep
☐ Loss of weight
☐ Nervousness
☐ Numbness

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

☐ Head
☐ Neck
☐ Shoulders
☐ Arms
☐ Hands
☐ Back
☐ Hips
☐ Knees
☐ Feet

EYE, EAR, NOSE, THROAT

☐ Crossed eyes
☐ Blurred vision
☐ Double vision
☐ Vision – Flashes or Halos
☐ Bleeding gums
☐ Earache
☐ Ear discharge
☐ Ringing in ears
☐ Loss of hearing
☐ Nosebleeds
☐ Sinus problems
☐ Hay fever
☐ Hoarseness
☐ Persistent cough
☐ Difficulty swallowing

CARDIOVASCULAR

☐ High blood pressure
☐ Low blood pressure
☐ Chest pain
☐ Rapid heart beat
☐ Irregular heartbeat
☐ Poor circulation
☐ Varicose veins
☐ Swelling of ankles

GENITO-URINARY

☐ Blood in urine
☐ Frequent urination
☐ Painful urination
☐ Lack of bladder control

GASTROINTESTINAL

☐ Poor Appetite
☐ Bloating
☐ Bowel changes
☐ Constipation
☐ Diarrhea
☐ Excessive hunger
☐ Excessive thirst
☐ Gas
☐ Hemorrhoids
☐ Indigestion
☐ Nausea
☐ Rectal bleeding
☐ Stomach pain
☐ Vomiting
☐ Vomiting blood

Please check all conditions you currently have or had in the past year.

☐ Arthritis
☐ Asthma/Bronchitis
☐ Cancer
☐ Cataracts
☐ Diabetes
☐ Emphysema
☐ Epilepsy
☐ Gout
☐ Heart Disease
☐ Hepatitis
☐ Hernia
☐ High Cholesterol
☐ Migraine Headaches
☐ Multiple Sclerosis
☐ Pacemaker
☐ Pneumonia
☐ Polio
☐ Stroke

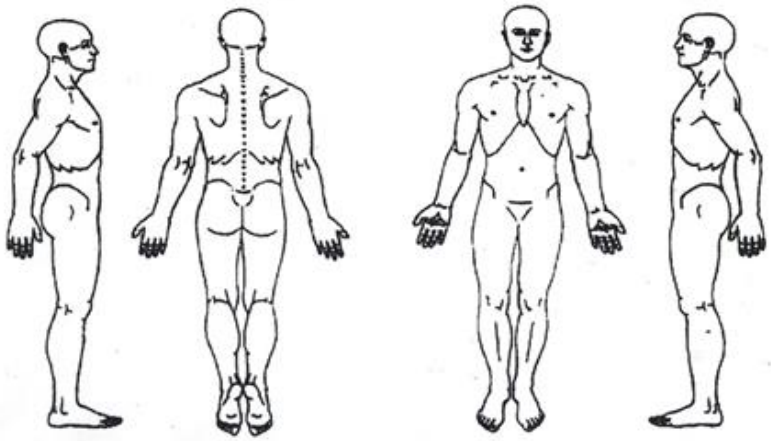
Patient/Guardian Signature: Date

Patient Health Report

A. Draw today's symptoms on the figure:

Shade in all areas of pain. Grade the intensity of pain in each area using 0 - 10 scale:

0 = no pain / no discomfort, 10 = the worst pain you can imagine



B. Identify the intensity of your symptoms.

Please circle one of the numbers to show the amount of pain you are experiencing today:

C. Please list any recent surgery dates. Describe any changes in your condition or any new concerns. You may also list your current medications.

Patient/Guardian Signature: Date:

HIPAA Privacy Rule and Notice of Privacy Practices

This notice describes how protected health information (PHI) may be used and disclosed and how you can get access to this information. Riverdale Sports Physical Therapy is required by law to protect the privacy of health information that may reveal your identity and to provide you with a copy of this notice which describes the health information privacy practices of our facility, staff and affiliated health care providers that jointly perform payment activities and business operations with our facility. Protected health information (PHI) is information about you, including present or future physical or mental health or conditions, and related health care services.

In compliance with HIPAA (The Health Insurance Portability and Accountability Act), Riverdale Sports Physical Therapy will not disclose your protected health information (PHI) without your explicit authorization, except as permitted by law for the purposes of payment, treatment and health care operations. Furthermore, Riverdale Sports Physical Therapy will limit the use, disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. This notice refers to Riverdale Sports Physical Therapy as "us" and "our," and to the patient/guardian as "I," "my," "you," "your," and "yourself."

If you choose to have your PHI communicated to individuals other than yourself or those mentioned above, please accurately complete and submit a medical records request form to Riverdale Sports Physical Therapy. You further agree to be responsible for notifying Riverdale Sports Physical Therapy if you wish to revoke or change these authorizations.

Federal Laws effective April 14, 2003 require patients to be given a notice of privacy policy formulated in accordance with HIPAA (The Health Insurance Portability and Accountability Act) and to sign a consent form and payment agreement. New York State Law requires all alternative healthcare practitioners to inform patients that they should consult western medical practitioners in regard to the condition for which they seek treatments.

Cancellations & No Shows

Cancellations must be made 12 hours in advance of the scheduled appointment time. There is a $25 fee if your appointment is canceled less than 12 hours prior to the appointment time. There is a $50 fee if you No Show your appointment.

The insurance company will not be charged for your missed appointment; you will be responsible for this payment out-of-pocket. Please be courteous to your Physical Therapists and fellow patients by arriving on time for your appointments.

Patient/Guardian Signature: **Date:**

Payment Contract

As a courtesy, we contacted your insurance company to inquire about your Physical Therapy benefits. Below is a summary of the information we were given. We strongly recommend that you also contact your insurance carrier and confirm your benefits as we are sometimes given incorrect information. Riverdale Sports Physical Therapy is not responsible for any inaccurate information we receive and will bill you for any balances that your insurance company indicates as your responsibility. Please let us know if you have any questions about your coverage.

Payment is requested at the time of your visit.

Patient is responsible for:

I (patient/guardian) hereby authorize direct payment of medical benefits to Riverdale Sports Physical Therapy (provider) for services rendered by provider in person or under provider's supervision. I understand that I am financially responsible for any balance not covered by my insurance. I certify that the information given by me in applying for payment is correct. I authorize the release of all records on request. I request that payment of authorized benefits be made on my behalf.

I acknowledge and agree to abide by the In Network benefit policies above.

It is my responsibility to make these payments without any need for periodic bills or other reminders of payments due.

Patient/Guardian Signature: **Date:**

Physical Therapy Services

Have you had Physical Therapy Services at any other facility within this calendar year?

Yes or No

If yes, what is the name of the facility?

Approximately how many times were you seen there?

Patient/Guardian Signature: **Date:**

Occupational Therapy Services

Have you had Occupational Therapy Services at any other facility within this calendar year?

If yes, what is the name of the facility?

Approximately how many times were you seen there?

Patient/Guardian Signature: **Date:**

Non-discrimination Policy

*RIVERDALE SPORT PHYSICAL THERAPY**shall operate in a manner that does not unlawfully discriminate against people on the basis of race, color, national origin, religion, sex (including pregnancy) age, sexual orientation (including gender identity and expression**)**, marital status, disability, veteran status, or any other basis prohibited by federal, state, or local law. RSPT prohibits retaliation against any person because he or she opposed or complained about discrimination in good faith, assisted in good faith in the investigation of a discrimination complaint, or participated in a discrimination charge or other proceeding under federal, state, or local anti-discrimination law.*

I confirm that I have read, understand and agree to the above policy

Patient/Guardian Signature: Date:

NOTICE OF ADVICE DIRECT ACCESS LAW

Pursuant to Chapter 298 of Laws of 2006, New York State law authorizes eligible physical therapists (with a minimum of three years of practical experience or the equivalent) to treat patients without a referral from a physician, dentist, podiatrist or nurse practitioner ("Direct Access Law"). However, the Direct Access Law does not apply to patients who are covered under workers' compensation insurance, no-fault insurance, Medicare or to patients who have pending liability cases.

IN ACCORDANCE WITH THE DIRECT ACCESS LAW, I ATTEST THAT:

I understand that my treatment may not be covered by my health care plan or insurer without a referral from a physician, dentist, podiatrist, or nurse practitioner and that my treatment may be a covered expense if rendered with a referral.

I understand that I am responsible for contacting my health care plan or insurer to determine whether my health care plan or insurer covers my treatment without a referral from a physician, dentist, podiatrist, or nurse practitioner.

I understand that treatment without a referral is limited to ten (10) visits or thirty (30) days, whichever occurs first.

Treatment will begin on _____.

Date

My treatment is not related to a no-fault injury or a workers' compensation covered injury, that there is no pending liability case related to my condition, and I am not insured through Medicare.

I understand that I am fully responsible for any and all costs associated with the direct access treatment session(s) that are due and owing Riverdale Sports, PT and not otherwise covered by my health care plan or insurer.

I attest that I have read and understand this Notice of Advice regarding New York State, Direct Access Law and I consent to receive physical therapy treatment from Riverdale Sports, PT without a referral from a physician, dentist, podiatrist, or nurse practitioner.

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Patient/ Legal Guardian's Name Signature of Patient or Legal Guardian Date

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Treating Physical Therapist's Name Treating Physical Therapist signature Date

Riverdale Sports Physical Therapy
531 W. 235th st
Bronx, NY 10463
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PATIENT QUESTIONNAIRE

Have you or any of your immediate family members come in contact with anyone who has tested positive for COVID-19?
YES OR NO

Have you had any COVID-19 symptoms or tested positive in the last two weeks?
YES OR NO

If yes, have you had any follow up testing?
YES OR NO

If so, what were the results?
_____

When was your last follow up test?

_____

Do you currently have any flu like symptoms (related or unrelated to COVID-19)
YES OR NO

Patient/Guardian Signature: **Date:**

INFORMED CONSENT FOR PHYSICAL THERAPY

Your licensed therapist works by referral from your physician to provide you with rehabilitation services appropriate for the problem(s) for which you seek care. Your therapist will design a treatment program specifically for your needs and goals. S/he is not legally bound by your physician's suggestions for therapy. In fact, a licensed physical therapist is bound by law and ethics to exercise his or her own, independent, professional judgment in the treatment of each patient.

Neither we, nor any physical therapist, can guarantee a positive outcome of your therapy or make any promises as to the degree of improvement or recovery you may receive.

I. Common Physical and Occupational Therapy Treatments

A. Procedures which may be utilized by your therapist:

- Exercise to build strength, flexibility, balance, coordination and endurance.
- Joint mobilization to reduce pain and improve joint mobility.
- Soft tissue mobilization and massage to loosen muscles, tendons, ligaments and scars.
- Manual or mechanical traction; gentle forces applied to separate joint surfaces, reduce pressure on surrounding tissues.
- Functional training and postural corrections to properly perform normal daily activities, work and recreational tasks such as bending, lifting and carrying.
- Gait training to improve walking and running, help with stairs and inclines.
- Taping of joints, and taping instruction for support and re- education.
- Relaxation training for voluntary quieting of the body and improved breathing pattern.

B. Modalities which may be used before, during or after treatment procedures:

- Ice packs to help control swelling and pain.
- Moist heat packs to help reduce pain and stiffness.
- Ultrasound and Diathermy to produce a deep heat for pain control and loosening soft tissues.
- Electrical Stimulation (Tens, A.R.T., Interferential) to help control pain, swelling, circulation and muscle contraction. If you have a pacemaker, metallic implants, are currently pregnant, or have a cancerous tumor, you must notify your therapist before treatment is started; the above listed treatments may need to be avoided.

II. Risks and/or Possible Side Effects Associated with Treatments

As is true with all medical care, there are potential risks and side effects of all treatments. The most common side effects of physical therapy are fatigue and temporary soreness of the muscles, tendons, joints or other tissues due to the treatment itself. These are usually transitory. Other possible but rare side effects may include allergic reactions to products used during treatment, superficial burns, superficial blistering or bruising, or electrical shock. The use of some electrical modalities may pose a risk to pregnant women or those with metallic implants or implanted heart or nerve stimulators. Prior to the beginning of your treatment regimen, be sure to ask your therapist for a detailed explanation of the possible side effects of any particular treatment. Your therapist will answer any inquiries you may have about your treatment procedures. Your health is dependent on your understanding of your treatment and its consequences. You have the right to refuse physical therapy or any part of your treatment as determined by your referring physician and your treating physical therapist. You have the right to request alternative modalities or procedures. If you choose, therapy may be limited to instruction of a home exercise program. However, your results may differ greatly from therapy recommended and provided by a licensed physical therapist. Our office policy prohibits us from performing patient-requested therapy that differs from the physician and therapist’s recommendation if such therapy can not be expected, in the therapist’s judgment, to benefit the condition for which the patient seeks relief.

III. Safety and Health Considerations

In consideration of the health and safety of both our patients and staff, this office enforces a policy relating to communicable diseases and conditions, including open and infected wounds.

A. We require anyone presenting with a chronic communicable (or potentially communicable) disease (e.g. TB, HIV, AIDS, hepatitis, certain skin diseases, etc.) or anyone with infected wounds or skin lesions to notify their treating therapist at their first visit. Your therapist has a legal and ethical responsibility to notify any staff member who will be in direct physical contact with that patient with such a condition. This allows us to take the appropriate precautions for affected parties. At the patient's request however, other non-treating staff need not be informed.

B. We reserve the right to cancel your treatment when you have an acute infection such as measles, flu, severe cold, bronchitis, etc., to help protect our staff and other patients.

IV. Personal Possessions

Riverdale Sports Physical Therapy assumes no risk for personal items lost or stolen from this facility. We encourage you to please leave your valuables at home whenever possible.

IV. Consent to Physical Therapy Treatment

I have read and understand the Informed Consent declaration. I agree to accept treatment as proposed and to be bound by the health and safety requirements of Riverdale Sports Physical Therapy.

Patient/Guardian Signature: Date:
