Duffy & Bracken

DATE: _____

Home Phone: (____) _____

Work Phone: (____) _____

Cell Phone: (____) _____

Email: _____

Emergency Contact: _____

Emergency Phone: _____

NAME: _____

ADDRESS: _____

CITY: _____

STATE: _____ ZIP _____

EMPLOYER: _____

ADDRESS: _____

JOB TITLE/OCCUPATION: _____

BIRTHDATE: ___/___/___ AGE: _____

SOCIAL SECURITY: _____ - _____-_____

MARITAL STATUS: _____ SEX: _____

HOW DID YOU HEAR ABOUT US? _____

To All Our Patients,

As you know, we are committed to providing you the very best physical therapy care. Unfortunately, Medicare and health insurance companies do not cover supplies that will be provided during your care. Due to increase in costs without increased reimbursements we can no longer absorb these fees. We will therefore be charging you for the costs of the supplies which are separate from any co-payment you may have. **Thank you for trusting us with your PT needs. It is truly our honor and privilege to serve you.**

Here is the list of supplies and costs:

1.	Probes	$60
2.	Taping	$5/session
3.	Kinesio tape	$5/session
4.	Electrodes	$10
5.	Heel raises	$10 each

SIGNED: _____

75 MAIDEN LANE, SUITE 404 – NEW YORK, NY 10038 – PHONE 212-402-5430 – FAX 212- 402-5432

Patient Name _____ *Date* _____

1. Describe your symptoms _____

_____

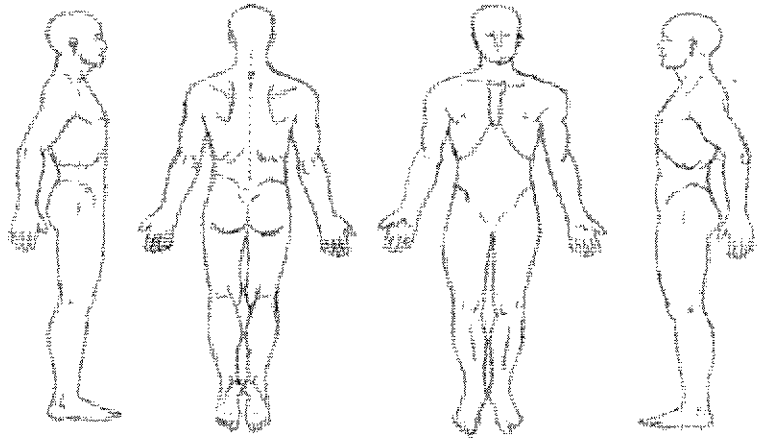
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ *Unbearable*

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

① No One ③ Medical Doctor ⑤ Other
② Chiropractor ④ Physical Therapist

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office ③ Medical Doctor ⑤ Other
② Chiropractor ④ Physical Therapist

10. What is your occupation?

① Professional/Executive ⑥ Laborer ⑦ Retired
② White Collar/Secretarial ⑤ Homemaker ⑧ Other
③ Tradesperson ⑧ FT Student

_____

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time ③ Self-employed ⑤ Off work
② Part-time ④ Unemployed ⑥ Other

Patient Signature _____ *Date* _____

Duffy & Bracken

PHYSICAL THERAPY, P.C.

FINANCIAL POLICY STATEMENT

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy or your responsibility.

If you provide our office with the necessary information regarding your insurance plan, we will submit our claim directly to your carrier. **You are responsible to pay the appropriate deductible, co-pays and/or coinsurance, also any denial of payments from your insurance.** We accept all major credit cards; however cash or check is preferred for services rendered. **It is the policy of this office to keep a credit card on file. Please provide credit card information below for any unpaid accrued charges.**

REGARDING INSURANCE

Physical therapy treatment can be provided without a prescription for the first 30 days or 10 treatments, whichever comes first but in some cases it may not be covered by your health care insurer without the referral of a physician or nurse practitioner, but may be a covered expense, if treatment was rendered pursuant to such referral.

If your plan requires authorization from your physician (primary or specialist), it is your responsibility to obtain the written referral or authorization prior to your visit at Duffy & Bracken. If you arrive at our office without proper authorization, full payment will be expected at time of service and refunded to you when authorization is obtained.

In addition, to comply with state regulations, you have to provide a prescription from your physician (primary care or specialist) within 30 days of the start of your treatment at Duffy & Bracken. Any denial of payment of services resulting from non-compliance with this policy will be billed to you.

Insurance is a contract between you and your insurance company. In most cases, we are NOT party to this contract. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, coinsurance, co-payments, referrals, "usual & customary charges," etc., other than to supply factual information as necessary. If you have not paid Duffy & Bracken and your insurance company inadvertently pays you directly, you must send this payment immediately to Duffy & Bracken. **Please note we will collect payment via credit card following five business days of notification of your check sent directly to you.**

The above does not apply for those patients that are considered Worker's Compensation. However be advised if your claim for Workers Compensation benefits is denied you may be held responsible for the total amount of charges for services rendered to you.

Duffy & Bracken preferred Method of Payment for deductibles and co-payments are:

Cash: $_____ Check: _____ Money Order: _____

Co-pays, co-insurance, deductibles and fee for service must be paid at time of treatment. A $10 service charge will be added if not paid on the day of your appointment.

It is the policy of this office to keep a credit card on file. Please provide credit card information below for any unpaid accrued charges and/or fees.

Credit/Debit Card: _____ Card #: _____

Expiration date: _____

RESPONSIBLE PARTY SIGNATURE **DATE**

_____ _____