SportsCare Physical & Aquatic Therapy

Medical/Physical History form

BACK/LOWER EXTREMITIES

Patient Name:_____ **Diagnosis:** _____ **Date:** _____

Age _____ **Height:** _____**inches** **Weight:** _____**lbs.**

Name of your doctor: _____ **Type of doctor:** : _____

Date of Injury: _____. **Date of Surgery:**_____ .

History of present illness/injury/pain:_____.

Primary Concern: (***Why am I here for physical therapy):***

Check all that apply:

1. Base level of function: □ **walking** □ **negotiating obstacles** □ **moving around** □ **standing** □ **stairs** **Lifting**
(<u>was</u> able to do) □ **running** □ **hopping** □ **squatting** □ **sleep** □ **shopping** □ **house keeping** □ **cooking**

2. Functional limitation(s): □ **walking** □ **negotiating obstacles** □ **moving around** □ **standing** □ **stairs** **Lifting**
(<u>can't</u> do) □ **running** □ **hopping** □ **squatting** □ **sleep** □ **shopping** □ **house keeping** □ **cooking**

Pain scale: ***(0 is best, 10 is worst)*****>>>** **worst:** **current:** **at best:**

Pain description: **Pain Behavior in 24 hour cycle:** **Pain frequency:**

Aggravating factors:

Better with:

General Health: Good

Previous history of similar symptoms: **How many episodes?** **The year of 1st episode?** _____

History of falls: **how many?**

Medical History: **No known significant Medical History**

□ Heart disease	□ Stroke	□ Joint replacement	□ Strain
□ Diabetes Type I	□ High blood pressure	□ Fibromyalgia	□ Sprain
□ Diabetes Type II	□ Obesity	□ Osteoarthritis	□ Bone fracture
□ Fainting spells	□ Pacemaker	□ Rheumatoid arthritis	□ Tendonitis
□ Lupus	□ Parkinson	□ Muscular dystrophy	□ Bursitis
□ Alzheimer's/Dementia	□ Traumatic brain injury	□ Cancer	□ Spinal surgeries
□ Hepatitis	□ Seizures	□ Shortness of breath	□ Allergies: _____

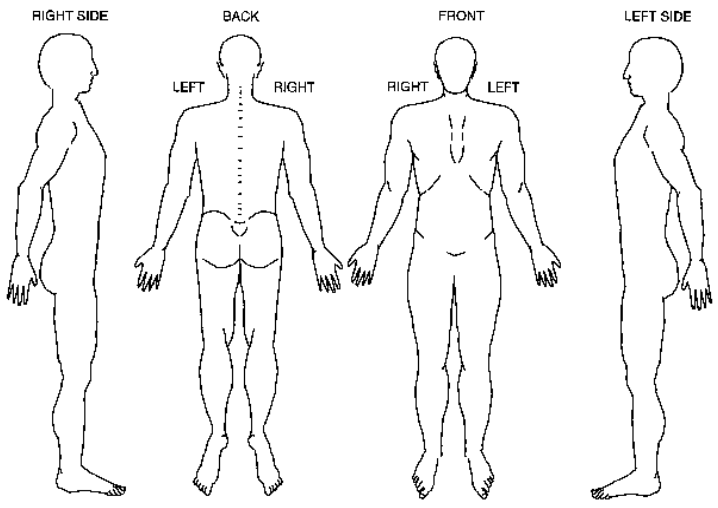
Diagnostic Testing/Imaging: □ **MRI** □ **CT scan** □ **X ray Findings**:

_____

What are your goal(s) in physical therapy?

_____

Identify the area(s) of your concern by moving your cursor over the site(s) of your symptoms and checking them off (X) >>>



OFFICIAL USE ONLY:

Total Score: ____ **pts.;** ____ **%**

Total Score: ____ **pts.;** ____ **%**

Back Index

ACN Group, Inc. Form BI-100

SportsCare Physical Therapy, PC (516) 420-1927

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____

SportsCare Physical Therapy, PC
814 Fulton Street
Farmingdale, NY 11735

MY MEDICATION RECORD

List prescriptions, over-the-counter drugs, vitamins and herbal medicines.

Patient name: _____ Date: _____

Allergies: _____

Pharmacy name: _____ Phone: (Off) _____

Primary doctor name: _____ Phone: (____) _____

Medication name/dose:	Medication treats (condition):	Medication frequency:	Notes/ questions:
		Off	
		Off	
		Off	
		Off	
		Off	
		Off	
		Off	
		Off	

Oswestry Low Back Pain Disability Questionnaire

Sources: Fairbank JCT & Pynsent, PB (2000) The Oswestry Disability Index. *Spine*, 25(22):2940-2953.

Davidson M & Keating J (2001) A comparison of five low back disability questionnaires: reliability and responsiveness. *Physical Therapy* 2002;82:8-24.

The Oswestry Disability Index (also known as the Oswestry Low Back Pain Disability Questionnaire) is an extremely important tool that researchers and disability evaluators use to measure a patient's permanent functional disability. The test is considered the 'gold standard' of low back functional outcome tools [1].

Scoring instructions

For each section the total possible score is 5: if the first statement is marked the section score = 0; if the last statement is marked, it = 5. If all 10 sections are completed the score is calculated as follows:

Example: 16 (total scored)

50 (total possible score) x 100 = 32%

If one section is missed or not applicable the score is calculated:

16 (total scored)

45 (total possible score) x 100 = 35.5%

Minimum detectable change (90% confidence): 10% points (change of less than this may be attributable to error in the measurement)

Interpretation of scores

0% to 20%: minimal disability:	The patient can cope with most living activities. Usually no treatment is indicated apart from advice on lifting sitting and exercise.
21%-40%: moderate disability:	The patient experiences more pain and difficulty with sitting, lifting and standing. Travel and social life are more difficult and they may be disabled from work. Personal care, sexual activity and sleeping are not grossly affected and the patient can usually be managed by conservative means.
41%-60%: severe disability:	Pain remains the main problem in this group but activities of daily living are affected. These patients require a detailed investigation.
61%-80%: crippled:	Back pain impinges on all aspects of the patient's life. Positive intervention is required.
81%-100%:	These patients are either bed-bound or exaggerating their symptoms.

Patient Name: Date:

Oswestry Low Back Pain Disability Questionnaire

Instructions

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We realise you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement which most clearly describes your problem.

Section 1 – Pain intensity

- ☐ I have no pain at the moment — 0
- ☐ The pain is very mild at the moment — 1
- ☐ The pain is moderate at the moment — 2
- ☐ The pain is fairly severe at the moment — 3
- ☐ The pain is very severe at the moment — 4
- ☐ The pain is the worst imaginable at the moment — 5

Section 2 – Personal care (washing, dressing etc)

- ☐ I can look after myself normally without causing extra pain — 0
- ☐ I can look after myself normally but it causes extra pain — 1
- ☐ It is painful to look after myself and I am slow and careful — 2
- ☐ I need some help but manage most of my personal care — 3
- ☐ I need help every day in most aspects of self-care — 4
- ☐ I do not get dressed, I wash with difficulty and stay in bed — 5

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain — 0
- ☐ I can lift heavy weights but it gives extra pain — 1
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed eg. on a table — 2
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned — 3
- ☐ I can lift very light weights — 4
- ☐ I cannot lift or carry anything at all — 5

Section 4 – Walking*

- ☐ Pain does not prevent me walking any distance — 0
- ☐ Pain prevents me from walking more than 1 mile — 1
- ☐ Pain prevents me from walking more than 1/2 mile — 2
- ☐ Pain prevents me from walking more than 100 yards — 3
- ☐ I can only walk using a stick or crutches — 4
- ☐ I am in bed most of the time — 5

_____

SportsCare Physical Therapy, PC (516) 420-1927

Patient Name: _____ **Date:** _____

Section 5 – Sitting

- ☐ I can sit in any chair as long as I like 0
- ☐ I can only sit in my favourite chair as long as I like 1
- ☐ Pain prevents me sitting more than one hour 2
- ☐ Pain prevents me from sitting more than 30 minutes 3
- ☐ Pain prevents me from sitting more than 10 minutes 4
- ☐ Pain prevents me from sitting at all 5

Section 6 – Standing

- ☐ I can stand as long as I want without extra pain 0
- ☐ I can stand as long as I want but it gives me extra pain 1
- ☐ Pain prevents me from standing for more than 1 hour 2
- ☐ Pain prevents me from standing for more than 30 minutes 3
- ☐ Pain prevents me from standing for more than 10 minutes 4
- ☐ Pain prevents me from standing at all 5

Section 7 – Sleeping

- ☐ My sleep is never disturbed by pain 0
- ☐ My sleep is occasionally disturbed by pain 1
- ☐ Because of pain I have less than 6 hours sleep 2
- ☐ Because of pain I have less than 4 hours sleep 3
- ☐ Because of pain I have less than 2 hours sleep 4
- ☐ Pain prevents me from sleeping at all 5

Section 8 – Sex life (if applicable)

- ☐ My sex life is normal and causes no extra pain 0
- ☐ My sex life is normal but causes some extra pain 1
- ☐ My sex life is nearly normal but is very painful 2
- ☐ My sex life is severely restricted by pain 3
- ☐ My sex life is nearly absent because of pain 4
- ☐ Pain prevents any sex life at all 5

Section 9 – Social life

- ☐ My social life is normal and gives me no extra pain 0
- ☐ My social life is normal but increases the degree of pain 1
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests eg, sport 2
- ☐ Pain has restricted my social life and I do not go out as often 3
- ☐ Pain has restricted my social life to my home 4
- ☐ I have no social life because of pain 5

Section 10 – Travelling

- ☐ I can travel anywhere without pain 0
- ☐ I can travel anywhere but it gives me extra pain 1
- ☐ Pain is bad but I manage journeys over two hours 2
- ☐ Pain restricts me to journeys of less than one hour 3
- ☐ Pain restricts me to short necessary journeys under 30 minutes 4
- ☐ Pain prevents me from travelling except to receive treatment 5

Total Score: _____

_____

SportsCare Physical Therapy, PC (516) 420-1927

17131

PT/OT Patient Intake Form
(version 1.5)
www.palladianhealth.com/members

Palladian

Last name		First name	

PLEASE COMPLETELY FILL IN THE ONE CIRCLE THAT BEST DESCRIBES YOUR ANSWER. (Example: ●)

1. Why are you here today? If there are many reasons, please choose only the most important or most severe one.

O Neck	O Shoulder	O Hip	O Stroke rehabilitation	**Other (also indicate region)**
O Upper/ mid-back	O Elbow	O Knee	O Spinal cord rehabilitation	O Post-surgical
O Lower back	O Wrist	O Ankle	O Neurologic rehabilitation	O Fracture
	O Hand	O Foot	O Balance/coordination	O Other

2. When did this problem first begin?

O Less than 1 month ago O 1-3 months ago O 4-6 months ago O 7-12 months ago O More than 1 year ago

	Has this problem...	No	Yes
3.	... resulted from a work injury (i.e. workers' compensation insurance claim)?	O	O
4.	... resulted from a motor vehicle accident (i.e. no fault insurance claim)?	O	O
5.	... recently been evaluated by a medical doctor?	O	O
	Since this problem began, have you noticed...	**No**	**Yes**
6.	... so much weakness in both your arms that you are unable to lift them?	O	O
7.	... so much weakness in both your legs that you are unable to walk without help?	O	O
8.	... difficulty controlling your bowel or bladder, or have you been unable to urinate?	O	O
9.	... pain in your chest, shortness of breath, or coughing up blood?	O	O
10.	... that one leg felt more warm, more swollen, more red, or more tender than the other?	O	O
	Have you recently...	**No**	**Yes**
11.	... had blurred vision, double vision, dizziness, or fainting?	O	O
12.	... had any type of infection, fever, or chills?	O	O
13.	... had any type of surgery, surgical procedure, or medical procedure?	O	O
14.	... lost a lot of weight without really trying to (i.e without being on a diet)?	O	O
15.	... had any type of accident, fall, or trauma?	O	O
	Have you ever...	**No**	**Yes**
16.	... been diagnosed with cancer?	O	O
17.	... been diagnosed with osteoporosis (i.e. weak, soft, or brittle bones)?	O	O
18.	... been diagnosed with a weakened immune system?	O	O
19.	... used any injected drugs (i.e. non-prescription drugs)?	O	O
20.	... used steroids such as prednisone for more than 4 weeks?	O	O
	Is this problem something that ...	**No**	**Yes**
21.	... you've had before?	O	O
22.	... generally gets worse (i.e more severe or frequent) with movement, activity, or exercise?	O	O
23.	... generally gets better (i.e. less severe or frequent) with rest?	O	O
24.	... was recently examined with diagnostic imaging tests such as x-rays, MRI scan, or CT scan?	O	O
25.	... is also being treated by a health professional other than a physical or occupational therapist?	O	O

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PT/OT Patient Outcomes Form
(version 1.5)
www.palladianhealth.com/members

Palladian

Last Name		First name	

PLEASE COMPLETELY FILL IN THE ONE CIRCLE THAT BEST DESCRIBES YOUR ANSWER. (Example: ●)

	Excellent	Very good	Good	Fair	Poor
1. In general, would you say your health is	O	O	O	O	O

The following questions are about activities you might do during a typical day.
Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	O	O	O
3. Climbing several flights of stairs	O	O	O

During the past week, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
4. Accomplished less than you would like	O	O	O	O	O
5. Were limited in the kind of work or other activities	O	O	O	O	O

During the past week, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
6. Accomplished less than you would like	O	O	O	O	O
7. Did work or other activities less carefully than usual	O	O	O	O	O

	Not at all	A little bit	Moderately	Quite a bit	Extremely
8. During the <u>past week</u>, how much did pain interfere with your normal work (including work outside the home and housework)?	O	O	O	O	O

These questions are about how you feel and how things have been with you during the past week.
For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the <u>past week</u>...	All of the time	Most of the time	Some of the time	A little of the time	None of the time
9. Have you felt calm and peaceful?	O	O	O	O	O
10. Did you have a lot of energy?	O	O	O	O	O
11. Have you felt downhearted and depressed?	O	O	O	O	O

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
12. During the <u>past week</u>, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?	O	O	O	O	O

How would you rate the severity of your main problem on a scale from 0 (not severe) to 10 (worst imaginable)?

	Not severe	0	1	2	3	4	5	6	7	8	9	10	Worst imaginable
13. Right now		O	O	O	O	O	O	O	O	O	O	O	
14. On average		O	O	O	O	O	O	O	O	O	O	O	
15. At its best		O	O	O	O	O	O	O	O	O	O	O	
16. At its worst		O	O	O	O	O	O	O	O	O	O	O	

PT/OT Treatment Form
(version 1.5)
www.palladianhealth.com/providers

Palladian

4287

PLEASE COMPLETELY FILL IN THE ONE CIRCLE THAT BEST DESCRIBES YOUR ANSWER. (Example: ●)

Specialty: O PT O OT
Location: O Office O Facility

Provider ID: 1700895646

Section A. Provider information

First name
Last name
Facility name: SportsCare Physical Therapy

Service Street Address: 814 Fulton Street, Suite B
Farmingdale, NY 11735

Check if
O Workers' compensation injury O No-fault injury

Section B. Patient information

First name
Last name
Health plan
Member ID

Date of (M M – D D – Y Y Y Y)
Birth
Onset
Last visit
Requested start

Section C. Primary region of complaint (select only 1 region)

Spine
O Cervical
O C/S+radiculopathy
O Thoracic
O Lumbosacral
O L/S+radiculopathy

Upper extremity
Shoulder O L O R
Elbow O L O R
Wrist O L O R
Hand O L O R

Lower extremity
Hip O L O R
Knee O L O R
Ankle O L O R
Foot O L O R

Other (also indicate region)
O Post-surgical
O Fracture
O Other

Rehabilitation
O Stroke
O Spinal cord
O Neurological
O Balance/coordination

Primary ICD-9 [.]

Section D. Red flags (i.e. signs or symptoms that may indicate potentially serious pathology)

Does this patient have any red flags (e.g. "yes" answers to PT/OT Patient Intake Form questions 6-20)? O No O Yes
Does this patient have any contraindications to receiving PT/OT care from you for this complaint? O No O Yes

Section E. Evaluation

Based on information provided by the patient, your examination, and your treatment history with this patient (if any), what is your evaluation of this patient's primary region of complaint? Please choose one box for each of these columns.

Symptoms	Physical function	Overall health	Prognosis
O Very mild	O Very good	O Very good	O Very good
O Mild	O Good	O Good	O Good
O Moderate	O Moderate	O Moderate	O Moderate
O Severe	O Poor	O Poor	O Poor
O Very severe	O Very poor	O Very poor	O Very poor

Section F. Management plan (i.e. how you plan on managing this patient's complaint)

Education about:	O Diagnosis	O Prognosis	O Remaining active	O Other	O None
Home/self-care:	O Heat/ice	O General exercise	O Specific exercises	O Other	O None
Supervised exercise:	O Strengthening	O Stretching	O Stabilization	O Other	O None
Modalities:	O Heat/ice	O TENS/EMS	O Ultrasound	O Other	O None
Manual therapy:	O Manipulation	O Mobilization	O Soft tissue	O Other	O None

Number of PT/OT visits used since last PT/OT Treatment Form was submitted:
O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10 O Other

Phone 516 - 420 - 1927 Fax 516 - 420 - 1952

Provider signature: X Date (/ /) MM / DD / Y Y Y Y

4287

V:PalladianPTOTtreatment(1.5)20100113

Note: By completing and signing this form below, the provider indicates that they:
1. provided/supervised all PT/OT services, and 2. are a participating PT/OT provider, and 3. provided all PT/OT services in a credentialed practice.

57344

PT/OT Pediatric Outcomes Form
(version 1.5)
www.palladianhealth.com/members

Palladian

Last Name		First name	

PLEASE COMPLETELY FILL IN THE ONE CIRCLE THAT BEST DESCRIBES YOUR ANSWER. (Example: ●)

1. In general, would you say your child's health is

Excellent	Very good	Good	Fair	Poor
○	○	○	○	○

During the past week, has your child been limited in any of the following activities due to HEALTH problems?

2. Doing things that take some energy such as riding a bike or skating?

Yes, limited a lot	Yes, limited some	Yes, limited a little	No, not limited
○	○	○	○

3. Bending, lifting, or stooping?

Yes, limited a lot	Yes, limited some	Yes, limited a little	No, not limited
○	○	○	○

4. During the past week, has your child been limited in the KIND of schoolwork or activities with friends he/she could do because of PHYSICAL health problems?

Yes, limited a lot	Yes, limited some	Yes, limited a little	No, not limited
○	○	○	○

5. During the past week, has your child been limited in the KIND of schoolwork or activities with friends he/she could do because of EMOTIONAL or BEHAVIORAL problems?

Yes, limited a lot	Yes, limited some	Yes, limited a little	No, not limited
○	○	○	○

6. During the past week, how much bodily pain or discomfort has your child had?

None	Very mild	Mild	Moderate	Severe	Very Severe
○	○	○	○	○	○

7. During the past week, how satisfied do you think your child has felt about his/her friendships?

Very satisfied	Somewhat satisfied	Neither satisfied nor dissatisfied	Somewhat dissatisfied	Very dissatisfied
○	○	○	○	○

8. During the past week, how satisfied do you think your child has felt about his/her life overall?

Very satisfied	Somewhat satisfied	Neither satisfied nor dissatisfied	Somewhat dissatisfied	Very dissatisfied
○	○	○	○	○

9. During the past week, how much of the time do you think your child acted bothered or upset?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
○	○	○	○	○

10. Compared to other children your child's age, in general would you say his/her behavior is:

Excellent	Very good	Good	Fair	Poor
○	○	○	○	○

How would you rate the severity of your child's main health problem on a scale from 0 to 10?

	Not severe	0	1	2	3	4	5	6	7	8	9	10	Worst imaginable
11. Right now		○	○	○	○	○	○	○	○	○	○	○	
12. On average		○	○	○	○	○	○	○	○	○	○	○	
13. At its best		○	○	○	○	○	○	○	○	○	○	○	
14. At its worst		○	○	○	○	○	○	○	○	○	○	○	

57344

SportsCare Physical Therapy, PC

Date of call_____ **Appt. date/time**_____

Name_____**Date of Birth**_____**SS#**_____

Address_____**City**_____**St** **Zip**_____

Home Phone_____ **Cell Phone** _____**Work Phone** _____

Spouse_____ **Email address**_____

If Child, Parents Names_____

Employer Name/Address_____**Occupation**_____

Emergency contact_____**Phone #** _____ **Relationship to patient** _____

Referring MD Off **Name** _____**Town**_____

Primary Care **Name** _____ **Town**_____

Which body part are you going to be treated for? _____

Was this the result of a car accident or work related injury?_ Yes No Date of accident _____

Did you have previous physical therapy this year? Yes No If yes, how many visits___Off_____

How did you hear about us? Off Family/Friend name: _____

What is your primary insurance? Off **Other :** _____

Name_____Address_____ Phone_____

ID# _____Grp# _____ Subscriber_____DOB:_____

Subscriber SS#_____ Relationship to patient_____

What is your secondary insurance? Off **Other:** _____

Name_____Address_____ Phone_____

ID# _____Grp# _____ Subscriber_____DOB:_____

Subscriber SS#_____ Relationship to patient_____

IF WORKERS COMP/NO FAULT INSURANCE, PLEASE FILL IN:

Name_____

Address_____Phone_____Fax_____

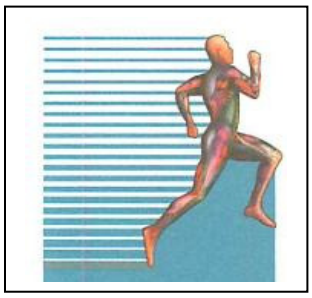
WCB#_____Carrier Case #_____File/Claim#_____

Policy #_____Policy Holder_____Claim Rep_____

Employer at time of accident_____

I authorize SportsCare Physical Therapy, PC to release any information to my insurance company that is necessary to expedite the payment of my claims. I understand that I am responsible for all charges not covered by my insurance including co-payments, co-insurance and deductibles. I understand that if my account is placed in collection, I am responsible for any and all fees associated with being placed into collection and legal proceedings. I also understand that it is my responsibility to obtain all necessary referrals and prescriptions when appropriate and that if said referrals are not obtained, I am responsible for the charges not covered under the referral. I authorize benefits to be paid to SportsCare Physical Therapy, PC. I authorize SportsCare Physical Therapy, PC to contact the insurance commissioner on my behalf. In the event that my workers compensation or no fault claim is denied, I will make arrangements with SportsCare Physical Therapy, PC to be paid by my private insurance and/or myself.

Patient Signature (or Signature of Parent or Guardian)_____Date_____



SportsCare Physical Therapy, PC
814 Fulton Street
Farmingdale, NY 11735
516-420-1927/516-420-1952
www.sportscareptpc.com

RELEASE OF INFORMATION

I give consent to SportsCare Physical Therapy, PC to disclose or request all or any part of the patient's medical record to any person or entity which is or may be liable under a contract to the facility, family member or employer of the patient for all or part of the facilities charge, including, but not limited to physical therapy services, insurance companies, workers compensation/no fault carriers, welfare funds or the patient's employer or any New York State or Federal agency per current rules and regulations. SportsCare Physical Therapy, PC has the authority to reject any unreasonable request by an office or institution if such request might violate the patient's right to privacy. I understand that confidentiality of my medical records are protected under state and federal law and that this release gives the consent to SportsCare Physical Therapy, PC only and not to any party to whom such information is released.

Patient/Responsible Party initials: _____

ASSIGNMENT OF BENEFITS

I hereby assign and set forth SportsCare Physical Therapy, PC sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers, or others who are financially liable for my medical care to cover the costs of care and treatment rendered to me or my dependent. I request that payment of authorized insurance benefits be made on my behalf directly to SportsCare Physical Therapy, PC.

Patient/Responsible Party initials: _____

CONSENT TO TREAT

I hereby request and consent to SportsCare Physical Therapy, PC to perform physical therapy treatment as prescribed by my physician and/or recommended by my physical therapist. I understand and am informed that, as in the practice of medicine, physical therapy treatment may have some risk. I understand that I have the right to ask about these risks and have any questions answered about my condition and treatment at any time during the course of my care. I authorize the physical therapist to provide any additional care or treatment, which is deemed necessary, should during the course of treatment such action be warranted. I understand that following an initial evaluation and appropriate re-evaluations, a description of my condition/diagnosis, presenting signs and symptoms, contraindications and precautions to treatment and expected benefits of treatment will be explained to me. I have read and understand this consent and authorize SportsCare Physical Therapy, PC (including physical therapist assistants and physical therapy students in training) to administer treatment under the direction and supervision of the physical therapist.

Patient/Responsible Party initials: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

SportsCare Physical Therapy, PC is committed to preserving the privacy of your personal health information. We have available a detailed notice of privacy practices which explain your rights and our obligations under the law. I acknowledge on this date that a copy of the NOTICE OF PRIVACY PRACTICES has been made available to me.

Patient/Responsible Party initials: _____

We value your time and as such, appointment times are at a premium. To get the best results from your treatment, it is imperative that you attend PT consistently. **If you cancel, please do so 24 hours in advance.** This will allow another patient to obtain that spot and receive their treatment. You may be subject to calling for available appointments (we will not pre book appointments) if you "No Show" (miss without calling) 3 visits. No Showing for appointments prevents someone else from receiving treatment and leaves us with an empty time in our work day. In addition, your insurance company may inquire about your attendance which may affect their determination in approving and paying for continued treatment. **Cancellations made within 24 hours of your appointment and "No Shows" will be charged a $25.00 fee.** This is neither billable nor payable by your insurance company and will be your responsibility.

Copayments are due upon arrival and prior to treatment. We accept cash, checks and credit cards (Visa, MC, Discover).

_____ Off _____/Off _____/Off _____
Patient/Responsible party signature Date

_____ Off _____/Off _____/Off _____
SCPT team member signature Date