Patient Medical History

Name	Referring Physician
Family Physician	Height: Weight:
Last date worked due to injury	Date returned to work after this injury

	Yes	No
Is an Attorney Involved in this case?		
Have you had Surgery for this injury?		
Type of Surgery		
Number of Surgeries 1 2 3 4		
Took place in: Hospital Or Surgery Center		

Are you currently taking any prescription or non prescription medication , If so Please list all Medication

Have you had any of the following Medical or Rehabilitative Service for this injury /Episode? _____

	Yes	No		Yes	No
Chiropractor			Ct Scan		
Emg/NCV			General Practitioner		
Massage Therapy			MRI		
Myelogram			Neurologist		
Occupation Therapy			Orthopedist		
Physical Therapy			Podiatrist		
Emergency Room Care			X-Rays		
Other					

Do you now have or have you ever had Any of the following?

	Yes	No		Yes	No
Asthma, Bronchitis or Emphysema			Severe or Frequent Headaches		
Shortness of Breath / Chest Pain			Vision or Hearing Difficulties		
Coronary Heart Disease or Angina			Numbness or Tingling		
Pacemaker/Defibrillator			Weakness		
High Blood Pressure			Weight Loss/Energy Loss		
Heart Attack			Hernia		
Stroke/TIA			Varicose Veins		
Blood Clot/Emboli			Allergies		
Epilepsy/Seizures			Any Pins or Metal Implants		
Thyroid Trouble/Goiter			Joint Replacement		
Anemia			Neck Injury/Surgery		
Infectious Disease			Shoulder Injury/Surgery		
Diabetes			Elbow Injury/ Surgery		
Cancer or Chemotherapy			Back Injury/Surgery		
Arthritis/Swollen Joints			Knee Injury /Surgery		
Osteoporosis			Leg/Ankle/Foot Injury/Surgery		
Gout			Dizziness or Fainting		
Sleeping Problems/Difficulties			Are you Pregnant?		
Emotional/Psychological Problems			Do you smoke?		
Bowel or Bladder Problems					

List Any other information that would assist you in your care _____

	Yes	No
Are you aware of what your diagnosis is?		

Based upon your awareness, What are your expectations/goals while in this program?

ASSIGNMENT OF BENEFITS

Patient Name: _____ I assign to Goodman Physical Therapy, PC all of my benefits and rights under any insurance contracts for payment of services rendered to me by Goodman Physical Therapy, PC. I authorize all information regarding my benefits under any insurance policy related to any claim to be released to Goodman Physical Therapy; I authorize Goodman Physical Therapy, PC to file insurance claims on my behalf for services rendered to me. I direct that all such payments go directly to Goodman Physical Therapy, PC. I authorize them to act in my behalf and report any suspected violations of proper claims practice to the proper regulatory authorities.

I authorize Goodman Physical Therapy, PC to obtain counsel and enter into legal or other action on my behalf and/or in my name, including the arbitration/dispute resolution process, to collect such sums due, should the sums not be paid within the legally prescribed timeframe. In the event that Goodman Physical Therapy, PC elects to bring a lawsuit or petition for arbitration/dispute resolution against the insurance carrier. I assign my rights and interest under the medical expense benefits and/or PIP section of any insurance policy under which I am entitled to proceed for benefits. This assignment shall allow an attorney of Goodman Physical Therapy, PC choosing to bring suit or submit to arbitration/dispute resolution their claim for any unpaid bills for services rendered for injuries that I sustained in this or any accident.

In the event that this assignment is held invalid for any reason, I hereby authorize Goodman Physical Therapy to appoint an attorney of their choice to represent me directly against an insurer from which I may collect PIP benefits and to bring a claim in a forum of his choice. This appointment is intended to enable the attorney to collect the bills of Goodman Physical Therapy, PC.

I agree and acknowledge that I may receive checks directly from the insurance carrier for services rendered by the provider. I agree to immediately forward said checks to Goodman Physical Therapy, PC upon receipt.

A photocopy of this assignment shall be as valid as the original. This assignment of benefits has been explained to my full satisfaction and I understand its nature and effect.

Patient Signature: _____ **Date:**_____

CONSENT FOR TREATMENT

1. **AUTHORIZATION:**
   a. I hereby authorize Goodman Physical Therapy's health care professionals and students to provide such medical care and to administer such treatment, necessary to the named patient or me each time I or the named patient present to an ambulatory care service. Such procedures and treatments may include, Physical Therapy, Occupational Therapy. To the extent possible I have been informed of risks and complications that may occur and alternatives that may be available.
   b. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from my treatment.

2. **MEDICARE PATIENTS:**
   a. I authorize any holder of medical or other information about me to be released to the Social Security Administration, its intermediaries, carriers and information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

3. **GUARANTEE OF ACCOUNT:**
   a. For and in consideration of services rendered to me by Goodman Physical Therapy, I hereby agree to pay the full bill for all charges which are not paid to Goodman Physical Therapy by insurance carriers, Worker's Compensation, No-fault or any balance due which is not covered by insurance or excluded by a co-insurance clause.

4. **RELEASE OF INFORMATION:**
   a. I authorize Goodman Physical Therapy to disclose all or part of the above patient's medical records to any person, corporation, or agency when required for the collection of benefits or payment of charges.

5. **HIPAA – NOTICE OF PRIVACY ACKNOWLEDGMENT:**
   a. Goodman Physical Therapy has made their Notice of Privacy Practices available to you. Your name, signature, time and date on this cover sheet indicate that you have acknowledged the availability of the Goodman Physical Therapy's Privacy Practices and were given the option to receive a copy for your possession. If you have any questions regarding the information set forth in the Notice of Privacy Practices, please do not hesitate to contact our Privacy Officer at Tele: 631/661-3180 or Fax Inquiries to: 631/661-3183

I confirm that I have read and fully understand the above.

Patient Name: _____ **Patient Signature:** _____

Relative/Guardian (if not patient): _____ _____
(Signature) (Print name)

Relationship (if signed by person other than patient) _____

(If Required) Interpreter: _____ _____
(Signature) (Print name)

Rep Name (Witness): _____ _____
(Signature) (Print name) (Date)