75 Maiden Lane Room 404
New York, NY 10038
(917)-455-4881
revolve.pt.nyc@gmail.com

Physical Therapy Intake Form

Personal Information

Name: ______________________ Date: ______________

Address: ______________________

Phone: ______________ Email: ______________

DOB: ______________ Sex: ______________

Who referred you? ______________________

History

Exercise Frequency: ______________ Exercise Type(s): ______________

Do you smoke? ________ Have you ever smoked? ________ How Often? ________

Are you pregnant? ______________ Do you have a Pacemaker? ______________

Allergies: ______________________

What medications are you currently using? ______________________

Previous complaints/surgeries: ______________________

Previous diagnoses/medications: ______________________

Complaint

What is your major complaint? ______________________

Start Date: ______________ Possible Cause: ______________

Symptoms: ______________________

Previous doctors seen for complaint: ______________________

Previous treatment for complaint: ______________________

Symptom-Aggravating Factors: ______________________

Symptom-Relieving Factors: ______________________

Time of Day Symptoms are Best: ______________ Time They Are Worst: ______________

Current Duration of Pain: ☐ Intermittent ☐ Constant ☐ With Certain Motions

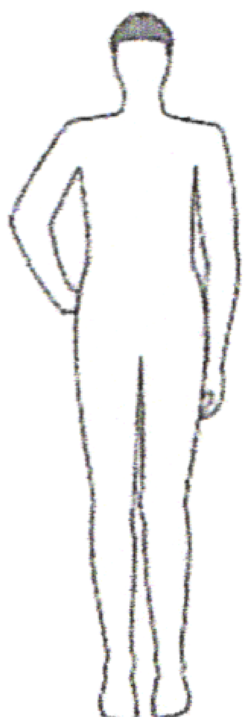
Current Level of Pain: ☐ Mild ☐ Moderate ☐ Severe ☐ Excruciating

Is your pain getting better or worse? ______________ Have you had this injury before? ______________

Do You Have Any of the Following Today? (Check All That Apply)

☐ AIDS/HIV	☐ Anemia	☐ Angina	☐ Arteriosclerosis
☐ Arthritis	☐ Asthma	☐ Blood Clots	☐ Bone Infection
☐ Cancer	☐ Chemical Dependency	☐ Circulation Problems	☐ Depression
☐ Diabetes	☐ Epilepsy	☐ Eye Infection	☐ Heart Problems
☐ Hemophilia	☐ High/Low Blood Pressure	☐ Joint/Bone Infection	☐ Liver Problems
☐ Lung Issues	☐ Multiple Sclerosis	☐ Musculoskeletal Problems	☐ Pneumonia
☐ Stroke	☐ STD	☐ Tuberculosis	☐ Urinary Infection

Mark Areas of Discomfort



Informed Consent

Physical therapy involves the use of many different types of physical evaluation and treatment. At Revolve Physical Therapy, we use a variety of procedures and modalities to help us to try and improve your function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy.

Since the physical responses to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your responses to a certain therapy modality or procedure. We are not able to guarantee precisely what your reactions to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain or injury, or may aggravate previously existing conditions.

You have the right to ask your physical therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms and testing results. You may also discuss with your therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time or during your treatment session.

Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercises, your therapist will be glad to answer them.

I acknowledged that my treatment program has been explained by Revolve Physical Therapy, and all of my questions have been answered to my satisfaction. I understand the risks associated with a program of Revolve Physical Therapy as outlined to me, and I wish to proceed. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I authorize the release of my medical information to appropriate third parties.

Patient Signature: ______________________________ Date: ______________

Office Signature: ______________________________ Date: ______________

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INSURANCE INFORMATION

Is your condition due to an auto accident or job related injury?____________________
Do you have health insurance?______________________________
Name of Company: ________________________ Policy #:________________

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Medical Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Medical Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature: ________________________ Date:________________
Guardian or Spouse Signature: __________________ SS#:________________
Doctors Signature: ________________________ Date:________________

Assignment/Direct Payment to Doctor Private/ Group Accident and Health Insurance

Patient: ________________________ Employer: ________________
Group NO:________________________ SSN/ID: ________________

I hereby instruct and direct my insurance company to pay by check made out and mailed to:

____

____

If policy provisions prohibit direct payment to physicians, I hereby also instruct and direct you to make out the check to me and mail to one of the addresses above. Payment is for the professional or medical expense benefits allowable and otherwise payable, to me under my current insurance policy as payment toward the total charges for professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in current manner, any balance of said professional services charges over and above this insurance payment. A photocopy of this Agreement of Rights and Benefits shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize a doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signature of Policy Holder: ______________________________ Date:____________

Witness: ____________________________________

PATIENT CONSENT OR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent to Revolve Physical Therapy PLLC to use and disclose my protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

Revolve Physical Therapy PLLC notice of privacy practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Revolve Physical Therapy PLLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Revolve Physical Therapy, 75 Maiden Lane Room 404, New York, NY 10038.

With this consent Revolve Physical Therapy PLLC may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent of Revolve Physical Therapy PLLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With the consent of Revolve Physical Therapy PLLC, they may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Revolve Physical Therapy PLLC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Revolve Physical Therapy PLLC to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Revolve Physical Therapy PLLC may decline to provide treatment to me.

Patient's Name:____ Date: ______________

Signature of Patient Legal Guardian:____

Print Name of Patient or Legal Guardian: ____