



Name:

DOB:

Date:

1. Please describe your current symptoms and your reason for coming to therapy:

2. How much of the time do you have symptoms?

Constant (76 – 100%)

Occasional (26 – 50%)

Frequent (51 – 75%)

Intermittent (25% or Less)

3. Indicate the intensity of your pain at rest:

No Pain

1

2

3

4

5

6

7

8

9

10

4. Indicate the intensity of your pain with movement:

No Pain

1

2

3

4

5

6

7

8

9

10

5. What makes your symptoms worse?

6. What makes your symptoms better?

7. On what date did your problem begin?

8. Describe how the problem began?

9. Have you had this problem before?

10. Please indicate your medical history. Check all that apply.

Heart Disease

Cancer

Osteoporosis

Low Back Pain

High Blood Pressure

Bronchitis

Rheumatoid Arthritis

Current Pregnancy

Pacemaker

Diabetes

Osteoarthritis

Stroke

Scoliosis

Fibromyalgia

Other: _____

11. Allergies None, Or List All: (including Latex)

12. Current Medications:

13. Present Occupation (including housewife, student or retiree):

14. Normal work status:

Full Time

Part Time N/A

15. Present status:

Full Time No Restrictions

Part Time No Restrictions

Unemployed

Full Time with Restrictions

Part Time with Restrictions

Not working due to Restrictions

16. What sports or hobbies do you participate in?

17. What are your goals for therapy?



Patient Information

Patient Name:	Account #:
Home Address	Home Phone:
City:	Alternate Phone:
Patient SSN:	DOB:
Email:	Referring Physician:
Insurance Provider:	Insurance ID:
Name of Insured/Responsible Party:	Insured's SSN:
Employer:	Insured's DOB:

Signature Required

If my insurance carrier denies payment for any reason, I am aware that I am financially responsible for payment of all services rendered.

_____ *Signature of Patient or Responsible Party* *Date*

Patient, Please Note: If this is an accident or work-related injury, and it is to be billed under 'No-Fault' or 'Worker's Compensation Insurance', Please provide all necessary information at your initial visit. Without this information we will have to bill you directly. Thank You.

For Office Use

<input type="checkbox"/> WCB	WCB Claim:
Number of Visits:	Number of Weeks:
Plan Type: <input type="checkbox"/> PPO In-Network	<input type="checkbox"/> Commercial Indemnity
Deductible Amount:	<input type="checkbox"/> Remaining balance: \$
Co-Pay for Office Visits: <input type="checkbox"/> No	Yes, Amount: \$
Representative's Name:	Direct Phone:
Claims Address:	Medicare Therapy Cap: 877 – 567 - 7173
	Deductible of: Has/Has not been met
	Total Applied to PT/OT:
Completed by:	Date:



ADIRONDACK
PHYSICAL & OCCUPATIONAL THERAPY

Adirondack Physical & Occupational Therapy, LLC
provides one-to-one, personalized care.

When you fail to keep your appointment, you are denying
someone else the benefit of that time slot.

Unless you provide 24 hours notice,
Adirondack Physical & Occupational Therapy, LLC
reserves the option to discharge a patient
who fails to attend 3 scheduled appointments.

Patient Signature

Date



Our Financial & Billing Policy

**Below is an outline of our practice’s billing policies and how they relate to you.
Please read them carefully.**

We participate with the following insurance companies:

- ✓ AARP
- ✓ BC/BS
- ✓ Special Funds
- ✓ Martin’s Point
- ✓ RMSCO: St Lawrence County
- ✓ Aetna
- ✓ Cigna
- ✓ Tricare
- ✓ Tricare for Life
- ✓ RMSCO: Lewis County
- ✓ Medicare
- ✓ GHI
- ✓ CHP
- ✓ GEHA
- ✓ RMSCO: Lewis County
- ✓ United Healthcare (Empire)
- ✓ Worker’s Comp (Most Carriers)
- ✓ No-Fault (Most Carriers)
- ✓ Medicaid (as Secondary Only)
- ✓ MVP
- ✓ MPN
- ✓ Pomco

If we do not participate with your insurance carrier: Provide us with the name and mailing address of your carrier, your policy number, group number, the Policy Holder’s full name, date of birth and social security number, and we will file the claim. *So that your insurance carrier reimburses you in a timely manner, as a courtesy, we will file these claims for you.* We will bill your insurance carrier only once per service. The patient is still responsible for payment of services within 30 days from the date of service.

Insurances that require referrals: If your insurance carrier requires a referral from your primary care physician, it is your responsibility to obtain the referral and to keep track of its expiration. Typically, a referral or prescription is valid for 30 days from the date it was written.

If we do not have a current referral in your chart, you will not be scheduled for future appointments until you provide one.

If you assign the benefits directly to this provider, we will file claims for your treatment with your insurance carrier.

Co-Pays: We have made arrangements with many carriers to accept an ‘assignment of benefits’. We bill them for your treatment and you are responsible for the co-pay at the time of your visit.

Not all insurance plans pay for all services. In every event, we will do what is necessary to know your coverage prior to your next scheduled appointment. In the event that your carrier will not cover a service, you will have the opportunity to consider other options.

If you have no insurance coverage: Arrangements are made on a case-by-case basis. Unless you have arranged a payment plan with our billing department, payment is due at the time services are rendered.

I have read and understand the financial and billing policies of ***Adirondack Physical & Occupational Therapy, LLC*** and ***I agree to be bound by these terms.*** I also understand and agree that, from time to time, such terms may be amended by the practice.

Signature of Patient or Responsible Part if a minor

Date

Please Print the name of the Patient

At your request, a copy of this policy is available to you.



Assignment of Benefits

I hereby authorize payment of medical benefits directly
to the provider of services listed above.

In addition, I understand that if payment is not received by the provider listed above
within 90 days of the billing date,

I am personally responsible to make direct payment.

I hereby authorize this facility to provide such medical care and to administer such
treatment as deemed necessary or advisable to me
each time I present to physical and occupational therapy.

I permit this facility to disclose all or part of the patient's medical record
to any person, corporation, or agency
when required for the collection of benefits or payment of charges.

Patient Signature

Date

