RECOUP PHYSICAL THERAPY

PATIENT INFORMATION

Name ______________________________________ Date of birth ____________ Age ___________

E-mail ____

Phone: Mobile (   ) _____ - ________ Work (   ) _____ - _________ Home (   ) ____-________

Address ____

City ______________________________ State ______________ Zip code __________________

Preferred method of contact: ☐ email phone: ☐ mobile ☐ work ☐ home

Referred by: ____

Occupation/Sport: ____

PARENT/GUARDIAN INFORMATION ☐ N/A

Name ____________________________ Relationship to patient ___________________________

Phone ______________________ E-mail ____

Address ______________________________ City _______________ State _____

Zip___________

Parental Consent for Treatment: As parent/legal guardian of

____

I authorize Terry Hwang, PT, DPT, OCS to treat while I am not present

Parent/Guardian signature: __________________________________ Date: _________________

EMERGENCY CONTACT

Name ____________________ Relationship to patient __________________________________

Address _______________________________ City _______________ State _____ Zip _________

Phone ____________________ E-mail ____

CURRENT INJURY HISTORY

What issue(s) are you coming to PT for? ____

When did the injury or symptoms first appear? ____

How did the injury/symptoms occur? ____

____

What are the current symptoms (pain/burning/numbness) and where are they on your body? ____

Please list your level of pain using a scale of 0 - 10 (0 = no pain; 10 = unbearable pain)

Current _____ /10 At Worst _____/10 At Best ____/10

Did you have any X-rays/MRI/CT scan of this body part? If yes, please indicate findings

____

Have you had surgery for this condition and when? ____________________________________

Patient's signature ____ Date ___________________

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GENERAL HEALTH HISTORY

To ensure that you receive a thorough and complete evaluation, please provide us with important background information on this form. If you are unclear regarding any of these questions, please leave it blank and your therapist will assist you.

Do you currently have or have you ever had any of the following?

Are you pregnant? ☐ N/A	☐ yes ☐ no	Hypoglycemia	☐ yes ☐ no
Diabetes	☐ yes ☐ no	Headaches	☐ yes ☐ no
High Blood Pressure	☐ yes ☐ no	Fevers/chills/sweats	☐ yes ☐ no
Heart Disease	☐ yes ☐ no	Unexplained weight chge	☐ yes ☐ no
Heart Attack/ Pacemaker	☐ yes ☐ no	Malaise (feeling unwell)	☐ yes ☐ no
Kidney Problems	☐ yes ☐ no	Unusual fatigue	☐ yes ☐ no
Cancer	☐ yes ☐ no	Nausea/Vomiting	☐ yes ☐ no
Osteoporosis	☐ yes ☐ no	Numbness/tingling	☐ yes ☐ no
Asthma/Breathing Difficulty	☐ yes ☐ no	Unexplained weakness	☐ yes ☐ no
Liver/Gallbladder Problem	☐ yes ☐ no	Dizziness/light headed	☐ yes ☐ no
Hernia	☐ yes ☐ no	Loss of consciousness	☐ yes ☐ no
Seizures	☐ yes ☐ no	Difficulty breathing	☐ yes ☐ no
Metal Implants	☐ yes ☐ no	Chest pain/palpitations	☐ yes ☐ no
Recent Fractures	☐ yes ☐ no	Swelling in feet or hands	☐ yes ☐ no
Surgeries	☐ yes ☐ no	Difficulty with swallowing	☐ yes ☐ no
Rheumatoid Arthritis	☐ yes ☐ no	Unexplained ⇅ in appetite	☐ yes ☐ no
Stroke/CVA	☐ yes ☐ no	Bowel/bladder changes	☐ yes ☐ no

If yes to any of the above, please briefly explain and provide approximate date ______________

____

Do you have any other medical issues or previous medical conditions not mentioned above?

____

____

Please list your current medications ____

Patient name ____

Patient signature ______________________________________ Date ____ /____ /____

RECOUP PHYSICAL THERAPY

OFFICE POLICIES
Patient/Responsible Party Name: ____

Consent to Treatment
__________ (initial) I give my consent for Theresa Hwang, PT, DPT to treat my condition within the scope of practice defined by the American Physical Therapy Association, and to provide physical therapy care and treatment considered necessary and proper in evaluating and treating my physical condition. I understand that this consent is intended as a waiver of liability for such treatment excepting acts of negligence.

Notice of Privacy & Electronic Communication Policies
__________ (initial) I hereby authorize Theresa Hwang, PT, DPT, having treated me, to release to government agencies, insurance carriers, and all others who are financially liable for my care, all information needed to substantiate payments for care and to permit representatives thereof to examine and make copies of all records related to such care and treatment. I understand that if at any point my insurance coverage changes, I am to notify the staff prior to my next visit. Failure to do so will result in my being responsible for the full amount of services.

Payment for Services
__________ (initial) I understand that Recoup Physical Therapy, PLLC is a fee-for-service clinic. Payment of all fees is expected at the time of service or via credit card on file. We will assist you in submitting claims to your insurance carrier. However, you are still responsible for any deductible, co-insurance/co-payments or claim denied by your insurance carrier. I authorize all payment of medical benefits directly to Recoup Physical Therapy, PLLC. for the services rendered. I agree to be responsible for all deductible and co-payment fees

Cancellation/No Show Policy
__________ (initial) I understand that there is a 24 hour cancellation policy and that I will be charged in full for all appointments that are not cancelled 24 hours in advance of the scheduled appointment time. I also understand that I will be charged in full if I fail to show up for my scheduled appt. as well.

Notice of Privacy Practices for Protected Health Information. Health Insurance Portability & Accountability Act of 1996 (HIPAA)
Due to increased awareness of the need for more strict guidelines regarding privacy of your PHI, the Health Insurance Portability & Accountability Act of 1996 (HIPAA) was legislated, effective April 14, 2003. As part of this law, Terry Hwang, PT, DPT is required to provide you with the option of receiving a copy of this notice.
__________ (initial) I am aware that this notice is available to me online at the clinic's website, www.recoupPT.com, and I choose to receive such notice electronically or I have requested to receive a paper copy of the above. I understand that it is my responsibility to read and be aware of these rights as outlined in the Notice.

I have read, understand, and agree to all the above terms

____ ______________
Signature of patient or authorized representative Date

RECOUP PHYSICAL THERAPY

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: ________________________________ Date of Birth: ____/____ /_____

INFORMATION TO BE RELEASED BY: RECOUP PT, 145 PALISADE STREET STE 200, DOBBS FERRY, NY 10522

INFORMATION TO BE RELEASED TO: COMBINED BILLING SERVICES, PO BOX 227, ARDSLEY ON HUDSON, NY 10503

This request and authorization applies to information relating to physical therapy, treatment, condition, follow up, or dates of treatment. I hereby consent to the release of the specified information relating to diagnosis, testing, or treatment to the person or entity named above so that my insurance may be billed for my treatment. I understand that such information cannot be released without my informed consent.
I understand that:

- My right to healthcare treatment is not based on the condition of this authorization.
- If I fail to specify an expiration date, this authorization will be valid indefinitely.
- I may revoke this authorization at any time by submitting a written request to the address provided at the top of this form.
- There may be a charge for copies of my medical records unless my copies are being sent to another physician, healthcare facility, or medical billing company. I acknowledge that I have fully reviewed and understand the contents of this authorization form.

Signature of Patient or Guardian: ______________________________ Date: ____/____ /____

Patient or Guardian Name: ____

Relationship to Patient, if other than Patient: ____

FOR BILLING QUESTIONS PLEASE CONTACT:
HELP@COMBINEDBILLINGSERVICES.COM
914-215-5335

Federal laws prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.