Ergo Physical Therapy
107-40 QUEENS BLVD. SUITE 207
FOREST HILLS, NY 11375
T 718-261-3100 / F 718-261-2915

PATIENT INTAKE FORM

Please complete ALL sections.

PERSONAL INFORMATION

LAST NAME **MIDDLE INITIAL** **FIRST NAME**

DATE OF BIRTH (MM/DD/YYYY) | **GENDER** ☐ Male ☐ Female | **SSN**

ADDRESS STREET CITY STATE ZIP

PHONE NUMBERS ☐ HOME ☐ WORK ☐ CELL

Please check the phone number at which messages should be left for you.

EMAIL ADDRESS

MARITAL STATUS ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Minor

EMPLOYER'S NAME | **OCCUPATION**

EMERGENCY CONTACT

LAST NAME **FIRST NAME**

RELATIONSHIP | **PHONE NUMBER**

REFERRAL

PRIMARY PHYSICIAN | **PHONE NUMBER**

REFERRING PHYSICIAN | **PHONE NUMBER**

SOURCE OF REFERRAL ☐ Family ☐ Friend ☐ Doctor ☐ Insurance ☐ Online (Google / Bing / Yahoo / Yelp / Other _____)

If ONLINE, please circle one or more sources that is appropriate.

Please submit ALL Insurance cards and your Photo I.D. to the Receptionist. If you do not have Insurance, you will be required to pay at the time of service. If your Insurance requires a referral and you do not have one at the time of service, you will be required to pay for the charges incurred. **All the information provided by me in the intake forms is accurate and correct to the best of my knowledge.**

PATIENT'S SIGNATURE (SPOUSE, OR PARENT/GUARDIAN IF PATIENT IS UNDER 18) | **DATE (MM/DD/YYYYY)**

PATIENT'S PRINTED NAME (SPOUSE, OR PARENT/GUARDIAN IF PATIENT IS UNDER 18)

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HEALTH HISTORY FORM

It is important to gather information about your medical history in order to provide you with the highest quality care. Please fill out this form to the best of your knowledge. Thank you!

Please check the boxes when appropriate.

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES/CONDITIONS?

HEART ATTACK/STROKE	☐ Y ☐ N	FREQUENT NECK PAIN	☐ Y ☐ N	HEPATITIS	☐ Y ☐ N
HEART SURGERY/PACEMAKER	☐ Y ☐ N	EMPHYSEMA/GLAUCOMA	☐ Y ☐ N	HIV AND/OR AIDS	☐ Y ☐ N
HEART MURMUR	☐ Y ☐ N	ANEMIA	☐ Y ☐ N	SHINGLES	☐ Y ☐ N
CONGENITAL HEART DEFECT	☐ Y ☐ N	HIGH/LOW BLOOD PRESSURE	☐ Y ☐ N	CANCER	☐ Y ☐ N
MITRAL VALVE PROLAPSE	☐ Y ☐ N	PSYCHIATRIC PROBLEMS	☐ Y ☐ N	CHEMOTHERAPY	☐ Y ☐ N
ARTIFICIAL VALVES	☐ Y ☐ N	RHEUMATIC FEVER	☐ Y ☐ N	ULCERS/COLITIS	☐ Y ☐ N
ALCOHOL/DRUG ABUSE	☐ Y ☐ N	SEVERE/FREQUENT HEADACHES	☐ Y ☐ N	ASTHMA	☐ Y ☐ N
VENEREAL DISEASE	☐ Y ☐ N	KIDNEY PROBLEMS	☐ Y ☐ N	DIFFICULTY BREATHING	☐ Y ☐ N
SINUS PROBLEMS	☐ Y ☐ N	FAINTING/SEIZURES/ EPILEPSY	☐ Y ☐ N	ARTIFICIAL JOINTS	☐ Y ☐ N
TUBERCULOSIS	☐ Y ☐ N	LOWER BACK PROBLEMS	☐ Y ☐ N	DIABETES (IF YES, ☐ TYPE I ☐ TYPE II)	☐ Y ☐ N

OTHER

FAMILY HEALTH HISTORY

LIST ANY ALLERGIES

LIST ANY PREVIOUS SURGERIES AND/OR INJURIES TYPE	DATE (MM/DD/YYYY)

IN GENERAL, WOULD YOU SAY YOUR OVERALL HEALTH RIGHT NOW IS ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

ARE YOU TAKING ANY MEDICATIONS? ☐ Yes ☐ No

IF YES, PLEASE LIST WHICH MEDICATIONS

If you are a Medicare patient, do NOT list any medications here. Please use Current Medicaiton Form seperately provided instead.

DO YOU TAKE SUPPLEMENTS/VITAMINS? ☐ Yes ☐ No

ARE YOU ON A SPECIAL DIET? ☐ Yes ☐ No

DO YOU SMOKE? ☐ Yes ☐ No

DO YOU EXERCISE? ☐ Yes ☐ No

ARE YOU WEARING HEEL LIFTS/ARCH SUPPORTS? ☐ Yes ☐ No

FOR WOMEN ONLY

ARE YOU PREGNANT? ☐ Yes (_____ months) ☐ No

ARE YOU NURSING? ☐ Yes ☐ No

ALL PATIENTS PLEASE COMPLETE THIS SECTION

WHAT ARE YOU BEING SEEN FOR TODAY?

WHO HAVE YOU SEEN FOR THIS CONDITION? ☐ Medical Doctor ☐ Chiropractor ☐ Physical Therapist ☐ Other (_____)

HAVE YOU RECEIVED ANY TREATMENT FOR THIS CONDITION?

HAVE YOU HAD ANY TEST DONE FOR THIS CONDITION? ☐ X-Rays ☐ CT Scan ☐ MRI ☐ Other (_____)

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INSURANCE INFORMATION FORM

PRIMARY INSURANCE	PRIMARY INSURANCE POLICY NUMBER
INSURED'S NAME	INSURED'S DATE OF BIRTH (MM/DD/YYYY)
SECONDARY INSURANCE	SECONDARY INSURANCE POLICY NUMBER
INSURED'S NAME	INSURED'S DATE OF BIRTH (MM/DD/YYYY)

ARE YOU THE POLICY HOLDER ON THE INSURANCE(S)? ☐ Yes ☐ No

If NO, please complete the following section.

POLICY HOLDER'S NAME

POLICY HOLDER'S DATE OF BIRTH (MM/DD/YYYY)	POLICY HOLDER'S PHONE NUMBER

PATIENT RELATIONSHIP TO POLICY HOLDER ☐ Self ☐ Spouse ☐ Dependant ☐ Other (_____)

ARE YOU SEEKING TREATMENT AS A RESULT OF A WORK RELATED INJURY? ☐ Yes ☐ No

ARE YOU SEEKING TREATMENT AS A RESULT OF A CAR ACCIDENT? ☐ Yes ☐ No

ARE YOU INVOLVED IN A LAWSUIT BECAUSE OF YOUR INJURY OR SYMPTOMS? ☐ Yes ☐ No

FOR MEDICARE PATIENTS ONLY

ARE YOU ENROLLED IN A MANAGED CARE MEDICARE PROGRAM? ☐ Yes ☐ No

ARE YOU RECEIVING ANY TYPE OF SERVICE FROM A HOME HEALTH CARE AGENCY (HOME ATTENDANT / NURSE / PT / OT) FOR ANY REASON? ☐ Yes ☐ No

If YES, please alert the front desk Receptionist immediately of the services you are receiving.

NOTICE OF PRIVACY PRACTICES

PATIENT ACKNOWLEDGEMENT OF REVIEW OF NOTICE

This is to acknowledge that I have reviewed ERGO PHYSICAL THERAPY, P.C. (the Practice's) Notice of Privacy Practices. Should I have any questions regarding this Notice of Privacy Practices, I understand that I can contact ERGO PHYSICAL THERAPY, P.C. at 718-261-3100.

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INSURANCE INFORMATION AND FINANCIAL AGREEMENT

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself.

I am ultimately responsible for understanding what my policy covers and does not cover.

As a courtesy, our office will contact your insurance carrier and do its best to verify your benefits in regards to our services.

I understand that ERGO PHYSICAL THERAPY, P.C. will bill my insurance carrier directly and prepare any necessary reports and forms to file claims.

Any amount authorized to be paid to ERGO PHYSICAL THERAPY, PC. will be credited to my account upon receipt. However, I clearly understand that I am personally responsible for payment regarding services rendered at this office if my insurance does not cover it. Every attempt will be made by our office to notify you what may or may not be covered by your insurance.

I hereby authorize ERGO PHYSICAL THERAPY, P.C. to: 1. Release and/or receive any medical information necessary to Insurance Carriers and/or Medical Doctors regarding my medical condition and treatment. 2. To process insurance claims generated in the course of the examination and/or treatment 3. To receive payment to the undersigned provider for services rendered.

I further understand that fees such as co-payment, co-insurance and/or deductible are due and payable on the date services are rendered and I agree to pay all such charges in full. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all additional cost ERGO PHYSICAL THERAPY, P.C. endures during the attempt to collect such fee. Listed but not limited to: collection agency fees, attorney and court fees)

I agree to the terms and conditions presented to me by ERGO PHYSICAL THERAPY, P.C. and I acknowledge and accept these terms and conditions set forth in the above section.

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CANCELLATION NO SHOW POLICY

PLEASE READ CAREFULLY.
THIS POLICY IS STRICTLY ENFORCED!

1. We require **24 hours notice** in the event of a cancellation. Please have an alternative appointment time in mind when you call to enable us to reschedule your appointment. This will ensure you get in the fully prescribed number of treatments that week.

2. There is a **$30 charge** for **ALL** no shows / cancellations without 24 hours prior notice. These charges will not be covered by your insurance or workers compensation, but will have to be paid by you personally.

3. In case of three consecutive no shows / cancellations, all remaining appointments may be cancelled and you will be referred back to your physician.

4. We take the subject of no shows / cancellations very seriously, because attendance can make the difference whether you fail or succeed in your rehabilitation. When you don't show as scheduled, three people are affected:

    - You, because you don't get the treatment you need as prescribed by your doctor and / or PT
    - Your PT who had the time reserved for you
    - Another patient who could have been scheduled for treatment if you had given proper notice

Please cooperate with us in this regard. We are looking forward to working with you!

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