GREENHAUS

**Physical Therapy**
Fitness & Wellness Center

**Anita Greenhaus, PT**
**Dr Mona Rajpal, PT, DPT**

Rehabilitation of Orthopedic & Sports Injuries

Fitness for People with Physical Limitations

Senior Fitness

Wellness Programs

Osteoporosis Prevention Programs

Post Mastectomy Programs

Nutritional Counseling

Massage Therapy

Date:_______________

Name_____________________________________________

Address___________________________________________

Town_____________________ Zip__________

Home Tel#__________________Cell#__________Work__________

Date of Birth_________________email address:_________________

How did you hear about us: **(Select one)**

Returnee________/Family___________/Friend____________/HSS__________

MD______/Walk-In_______/Website______/CareConnect_______Other________

Medications_____________________________________________

Health: Please answer all circling Y or N

| | | | | | |
|---|---|---|---|---|---|
| Heart Disease | Y | N | Epilepsy | Y | N |
| HBP | Y | N | Diabetes | Y | N |
| Heart Attack | Y | N | Arthritis | Y | N |
| Stroke | Y | N | Chronic Illnesses | Y | N |
| Asthma | Y | N | Fractures | Y | N |
| HIV | Y | N | Other joint problems | Y | N |
| Cancer | Y | N | Surgeries | Y | N |
| Pacemaker | Y | N | Other _________________ | | |

This year, have you received physical therapy for you present ailment? Y N
This year, have you received physical therapy for any other ailment? Y N
Have you been seen by a Podiatrist this year? Y N
Have you fallen two or more times in past year, without sustaining an injury or have fallen with injury in the past year? Y N
I have an in-network deductible plan: Y N

Emergency Contact:________________Phone #________________

Signed______________________*PT Signature* ________________

150 Woodbury Road Suite 4, Woodbury, New York 11797 • 516.367.1111 • Fax 516.367.3701

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# GREENHAUS PHYSICAL THERAPY FITNESS & WELLNESS CENTER

| Patient's Name: LAST, FIRST | INSURANCE | MEMBER ID # |
|---|---|---|
| | | |

**Patient Acknowledgement of Financial Responsibility**
This office does the best it can to determine the limits of insurance coverage that patients' have. However, in the health care industry today, insurance plans, and their limitations change daily. ***Therefore, it is the patients' responsibility to determine that he/she will be covered by their insurance plan***. The undersigned, in consideration of services rendered or to be rendered by Greenhaus PT agrees to be responsible for the fees for the services rendered to the extent that said fees are not paid by my insurance company. I also consent to receiving physical therapy procedures performed in this office and have discussed my diagnosis and treatment with the treating therapist.

This office appreciates and values patients' time. This office does not "double and triple book". Wait time is minimal to nil. Last minute cancellations result in lost time for the therapist, as well as an inability to refill the time slot. Therefore I acknowledge notification from Greenhaus PT that, if I cancel my appointment less than 24 hours in advance more than two times, future appointments will be made on a same day basis only. ***In addition, there is a $45 charge for "no-shows" & a $35.00 for "same day cancellations.***

I authorize the release of any health information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below ***[HCFA 12]***. I authorize payment of medical benefits to the undersigned physician or supplier for services described below ***[HCFA 13]***. A photocopy of this authorization shall be as effective and valid as the original.

If my treatment is being reimbursed by No-Fault patient, I realize that I cannot be treated by a chiropractor or acupuncturist on the same day that I have my physical therapy.

In addition, I request that payment from my secondary insurance company be made to Greenhaus PT for services rendered. However, if my payment by my secondary insurance company to Greenhaus PT requires there to be paper billing, I agree to reimburse physical therapy for the secondary payment on a self-pay basis.

Patient's Condition Related To ***[HCFA section 10]*** Circle one: Yes or No

| | |
|---|---|
| a. Employment?(Current or Previous) | Yes No |
| b. Auto Accident? | Yes No [Place (State) _______] |
| c. Other Accident? | Yes No |

Signed________________________________________Date_______________

**Patient Acknowledgement of Receipt of Privacy Practice Notice**
This is to acknowledge I have received and reviewed Greenhaus PT's Notice of Privacy of Practice. If I have any questions, I can contact the practice at 516-367-1111.

I, ___________________________, do____, do not____ give permission for any staff member of **Greenhaus PT** to speak with a family member or individual regarding appointments, test results, or picking up information on your behalf. Please list the individuals that we may speak with:

Name:_____________________________Relationship______________

Name:_____________________________Relationship______________

Please indicate by circling yes or no, where we can leave a message:
Home Answering Machine Yes No
Cell Phone Yes No
Business Number Yes No

Signed________________________________________Date_______________