Phone: 631-242-9200
Fax: 631-242-9202


2100 Deer Park Ave - Ste 5
Deer Park, NY 11729

**PATIENT INFORMATION** **EMAIL ADDRESS:**_____

| | | | |
|---|---|---|---|
| First Name: | Last Name: | Middle Initial: | Date: / / |
| Address: | City: | State: | Zip: |
| Birth date: / / | Age: | ☐ Male ☐ Female | S.S. #: - - |
| Home Phone: ( ) - | Alternative Phone (Cell, Pager): ( ) - | | Spouse: |

Chose Clinic Because/ Referred to Clinic By ☐ Dr.: ☐ Insurance Plan ☐ Family ☐ Friend

☐ Former Patient ☐ Close to Work/Home ☐ Website ☐ Yellow Pages ☐ Street Sign ☐ Other:

**WORK INFORMATION**

| | | |
|---|---|---|
| Employer: | Work Phone ( ) - | Ext. |
| Occupation: | Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed | |

**CARE PROVIDER INFORMATION**

| | |
|---|---|
| Referring Dr: | Referring Dr. Phone: ( ) - |
| Regular Dr./PCP | Regular Dr./PCP Phone: ( ) - |

**INSURANCE INFORMATION** **(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)**

| | | |
|---|---|---|
| Primary Insurance Name: | | |
| Subscriber's Name (If different): | | Birth date : / / |
| ID. #: | Group/Policy # | |
| Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: | | |
| Name of Secondary Insurance: | | |
| Subscriber's Name: | | Birth date : / / |
| ID. #: | Group/Policy # | |
| Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: | | |

**AUTO OR WORK INJURY CLAIM** **(PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)**

| | | | |
|---|---|---|---|
| Insurance Name: ☐ Auto : | ☐ Labor & Industries: | | |
| Adjuster/Claim Manager: | | Phone: | Ext.: |
| Address: | City | State: | Zip: |
| Claim #: | Accident Date: / / | Cause: | |

**ATTORNEY INFORMATION**

| | | | |
|---|---|---|---|
| Name: | Law Firm: | Phone: ( ) - | |
| Address | City | State: | Zip: |

**IN CASE OF EMERGENCY**

| | | |
|---|---|---|
| Name of Local Friend or Relative (Not Living at Same Address): | | |
| Relationship to Patient: | Home Phone: ( ) - | Work Phone: ( ) - |

I authorize my insurance benefits be paid directly to Paragon Physical Therapy. I understand that I am financially responsible for any balance. I also authorize Paragon Physical Therapy to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE DATE

Phone: 631-242-9200
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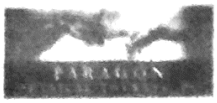

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# PAST MEDICAL HISTORY FORM

Patient Name _____

| BLOOD PRESSURE | YES | NO |
|---|---|---|
| Hypertension | ☐ | ☐ |
| Low Blood Pressure | ☐ | ☐ |
| Normal Blood Pressure | ☐ | ☐ |

| HEART DISEASE | YES | NO |
|---|---|---|
| Heart Attack | ☐ | ☐ |
| Atherosclerotic Disease | ☐ | ☐ |
| Myocardial Infarction | ☐ | ☐ |
| Rheumatic Heart Disease | ☐ | ☐ |
| Heart Murmur | ☐ | ☐ |
| Do you have a pacemaker | ☐ | ☐ |

| MUSCLE CONDITION | YES | NO |
|---|---|---|
| Carpal Tunnel R/L | ☐ | ☐ |
| Tennis Elbow R/L | ☐ | ☐ |
| Back/Neck Problems | ☐ | ☐ |
| Limited Limb Movement | ☐ | ☐ |

| LUNGS | YES | NO |
|---|---|---|
| Asthma | ☐ | ☐ |
| Emphysema | ☐ | ☐ |
| Shortness of Breath | ☐ | ☐ |

| JOINT CONDITIONS | YES | NO |
|---|---|---|
| Upper Extremity | ☐ | ☐ |
| Dislocation | ☐ | ☐ |
| Lower Extremity Dislocation | ☐ | ☐ |

| OTHER CONDITIONS | YES | NO |
|---|---|---|
| Muscular Dystrophy | ☐ | ☐ |
| Rheumatoid Arthritis | ☐ | ☐ |
| Multiple Sclerosis | ☐ | ☐ |
| Epilepsy | ☐ | ☐ |
| Gout | ☐ | ☐ |
| Fibromyalgia | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Hearing Loss | ☐ | ☐ |
| Poor Eyesight | ☐ | ☐ |
| Fainting | ☐ | ☐ |
| Polio | ☐ | ☐ |

Other: _____

**EXERCISE**
- ☐ None
- ☐ 1-2 x Week
- ☐ 3-4 x Week
- ☐ 5+ x Week

**WORK ACTIVITY**
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

**STRESS LEVEL**
- ☐ Low
- ☐ Medium
- ☐ High

**HABITS**
- ☐ Smoking — Packs a Day ____
- ☐ Alcohol — Drinks a Week ____
- ☐ Coffee/Soda — Cups a Week ____

What types of exercise do you perform? : _____
What things cause stress in your life? :

Are you taking any seizure medication? ☐YES ☐NO If yes list name: _____

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?

☐YES ☐NO If yes list name: _____

List all medications you are currently taking: _____

List all surgeries in the past two years (Including dates): _____

Are you pregnant? ☐ YES ☐ NO What week?: _____

Have you had any injuries related to work? ☐ YES ☐ NO If yes list body part and date.: _____

Have you had any Auto Accidents ☐ YES ☐ NO If yes list body part and date.: _____

Have you had Physical Therapy or Massage Therapy before? ☐ YES ☐ NO Where:

_____ _____

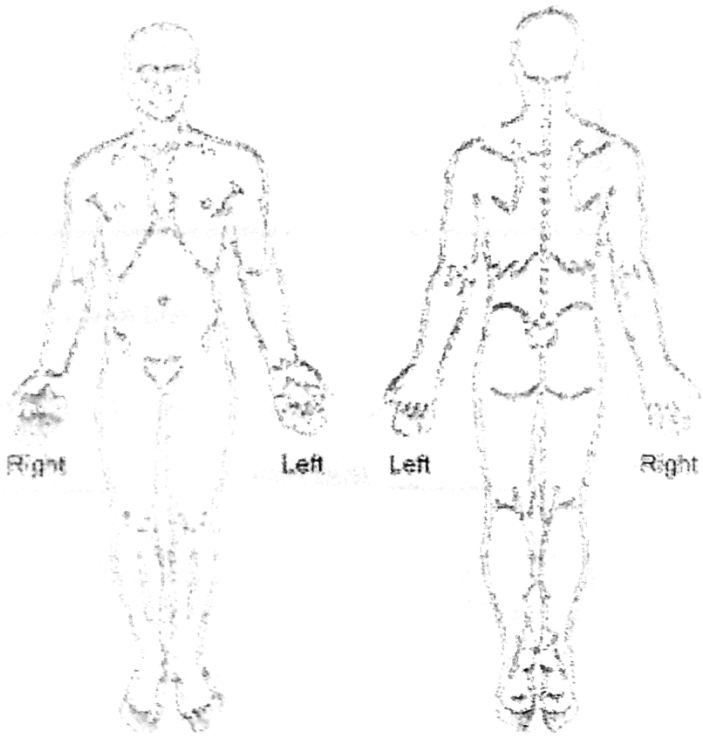
Signature of Patient, Parent, Guardian, Personal Representative Date

## *Pain and Symptom Status Report*

Name _____ Date _____

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing.

| Ache | Burning | Numbness |
|---|---|---|
| MMMM | --- | OOOO |
| MM | -- | OOO |
| **Pins & Needles** | **Stabbing** | **Other** |
| □□□□□□□□ | //////// | XXXX |
| □□□□□□ | ///// | XXX |




## *Chief Complaint and Visual Analog Scale*

My Chief Complaint is: _____

Date First Symptom of Your Problem Occurred on: _____

2nd Complaint: _____

3rd Complaint: _____

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Please circle on the scale below to indicate your CURRENT level of pain:** | | | | | | | | | | | | |
| **No Pain** | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **Pain as bad as it gets** |
| **Please circle on the scale below to indicate your AVERAGE level of pain:** | | | | | | | | | | | | |
| **No Pain** | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **Pain as bad as it gets** |
| **Please circle on the scale below to indicate your WORST level of pain:** | | | | | | | | | | | | |
| **No Pain** | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **Pain as bad as it gets** |

Additional Comments: _____

_____

PARAGON

Physical Therapy, PC

2100 Deer Park Ave. – Ste 5

Deer Park, NY 11729-[illegible]

242-[illegible] fax 631-[illegible]

**Patient Medication Intake List**

Please list all your current medications, your dosage and the frequency of each below.

Patient Name: _____ Patient DOB:_____

| Name of Medication: | Dosage: | Frequency: | Route of Administration: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Please notify us of any changes in the above as soon as possible.

# ASSIGNMENT OF BENEFITS

Dear Patient:

As a patient of PARAGON Physical Therapy, PC we are able to accept your insurance for services performed. We will submit a claim for your therapy procedures to your insurance company. While we are happy to provide this billing service to our patients, we do need your cooperation. By signing the Assignment and Release section below you are authorizing your insurance company to send their payment directly to us instead of yourself. **Should an insurance company send a reimbursement check directly to you for services rendered here, you agree to send that check as payment to us immediately after endorsing the back of the check as follows:**

**ENDORSEMENT:**
**Pay to the order of:**
**PARAGON Physical Therapy, PC**

**MAIL CHECK TO:**
**PARAGON Physical Therapy, PC**
**2100 Deer Park Ave – Ste 5**
**Deer Park, NY 11729**

**ASSIGNMENT and RELEASE: I Hereby Assign to the healthcare provider indicated above all rights, privileges and remedies to payment for health care service provided by the assignee to which I am entitled under insurance law. The assignee hereby certifies that they have not received any payment for or on behalf of the assignor (patient) and shall not pursue payment directly from the assignor (patient) for services provided by said assignee. Notwithstanding any prior written agreement to the contrary, this agreement may be revoked by the assignee when payments are not payable based on the assignor's (patient) lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor (patient). I also authorize the release of any medical or other information necessary to process my claims.**

Patients or Authorized Person's

Signature_____ Date_____

PARAGON
Physical Therapy, PC
90 N. Industrial Court
Deer Park, NY 11729
631-242-9200 fax 631-242-9202

# Physical Therapy Attendance Policy

**(Please read thoroughly)**

***Paragon Physical Therapy*** strives to provide each patient with the highest quality of care while attempting to accommodate your schedule for your convenience. Therefore, we provide reserved time slots for each patient with a specific therapist in order to minimize your waiting and assure continuity of your treatment. Your consistent attendance of the planned treatment regimen is paramount to your full recovery.

While we are sensitive to the fact that an emergency may occur in a rare instance, cancellations, especially last minute ones, along with patient no-shows, decrease our ability to accommodate the scheduling needs of the other patients. Additionally, no-shows display a complete lack of respect for your therapist and fellow patients. We must ask for your full cooperation with the following policy:

- If you are more than 30 minutes late for your appointment and fail to notify us, treatment may be cancelled and a fee charged for missing the appointment.
- A scheduled appointment MUST BE CANCELLED PRIOR TO YOUR APPOINTMENT TIME or a fee will be charged for that appointment.
- Failure to show up for an appointment ("NO SHOW") without notifying us will result in a fee being charged for that appointment. Furthermore, 2 consecutive no-shows will result in the cancellation of all remaining scheduled appointments.
- At week's end, ALL PATIENTS, regardless of insurance/third party payor, will be charged a $60 CANCELLATION FEE for each late, late-cancelled, or no-show appointment. THE PATIENT IS RESPONSIBLE FOR THE FEE, NOT THE INSURANCE/THIRD PARTY PAYOR.
- No cancellation fee will be charged if the missed appointment is made up within the same week it was scheduled on a day that you do not have another appointment scheduled.
- All cancellations and no-shows will be documented in your medical record and appropriately reported to your physician and insurance/third party payor.
- Repeated failure to comply with this ATTENDANCE POLICY will result in your name being placed on a "Schedule Based on Availability" list. This will require you to call for an open appointment on each day you would like to receive therapy. We will do everything possible to accommodate you, as space on the schedule permits.

We believe that this policy is necessary for the benefit of all our patients, so that we may continue to provide high quality treatment and service to everyone.

All of the staff at ***Paragon Physical Therapy*** appreciates your anticipated adherence and cooperation with this policy. We wish you the best of luck with your treatment. We are here to help you attain all of your goals and optimize your return to all of your pre-injury activities.

_____ _____

Patient Acknowledgement/Signature Date

PARAGON Physical Therapy, PC
2100 Deer Park Ave. – Ste 5
Deer Park, NY 11729
631-242-9200
Fax: 631-242-9202

## FINANCIAL POLICY

While you are here at PARAGON Physical Therapy, PC, a few rules of the road:

**Assignment of Benefits:** PARAGON Physical Therapy,PC will process all claims for payment. Therefore, we require you to sign an "Assignment of Benefits" form which we will keep on file.

If you wish to handle the claims process personally, the treatment fee must be paid at t he time of service.

**Referral & Pre-Certification:** Please be sure to know your insurance coverage and co-payments before your treatment starts. If your insurance requires a referral or pre-certification by your primary care physician, be sure to bring it in with you. If subsequent referrals are required, you will be responsible to hand them in when due.

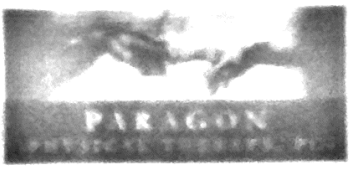
If you miss authorized visits, you will not be able to make them up.

**Co-Payments:** Your co-payment is due at the beginning of each treatment. You may pay by cash, or check. Co-payments cannot be reduced or waived.

Your financial responsibility is any portion of your deductible that has not been satisfied, and any dates of treatment not covered by your insurance. If you have any questions regarding coverage we urge you to call your insurance carrier.

Signature_____Date_____

Phone: 631-242-9200
Fax: 631-242-9202

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## CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Your protected health information will be used by this practice, known as Paragon Physical Therapy, PC or disclosed to others for the purpose of treatment, obtaining payment or supporting the day-to-day health care operations of the practice.

We are providing you with a copy of our Notice of Privacy Practices. We request that you review the notice prior to signing this consent. You may request a restriction on the use or disclosure of your protected health information. If you wish to restrict your disclosure, you should make that request in writing.

This practice, however, may or may not agree to restrict the disclosure of your protected health information.

If we agree to your request, the restrictions will be binding. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of federal privacy standards.

You may revoke the consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date of your revocation of consent is received will not be affected.

This practice reserves the right to modify the privacy practices outlined in the notice.

**SIGNATURE**

I have reviewed this consent form and have reviewed the Notice of Privacy Practices. I give my permission to this practice to use and disclose my health information in accordance with it.

_____

Name of Patient (Print Clearly)

_____

Signature of Patient Date

_____

Signature of Patient Representative

_____

Relationship of Patient Representative to Patient