Feldman Physical Therapy, PLLC ■ (P) 845-475-8769 ■(F) 845-746-2298

PATIENT INFORMATION

Name: _____ Today's Date: _____
Last First Middle Initial

Address: _____
Street

_____
City State Zip

Bill to: _____
Street

_____
City State Zip

Home Phone:( )_____ Cell Phone:( )_____
E-mail: _____ Patient Sex: M F
Marital Status: Single ____ Married ____ Other ____ Birth Date: _____
****

Occupation: _____
Status: Employed ___ Retired ___ Student ___ Not Working ___
Employer Name: _____ Phone: ( ) _____
Address:_____
Street City State Zip
****

Primary Care Physician: _____ Referring Physician: _____
Date of Injury: _____ Is this injury Job-Related? Y N or Automobile Accident-Related? Y N
How did you first hear about Feldman Physical Therapy?

_____
In case of emergency, contact: _____ Phone: ( ) _____
****

I hereby certify that all information is true to the best of my knowledge, and I am responsible for all charges incurred for these services.

Patient's Signature (Guardian if under 18): _____Date:_____

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OFFICE POLICIES & PROCEDURES

Welcome and thank you for choosing Feldman Physical Therapy, for your Physical Therapy needs.

New York state allows for "direct access" which means you can be evaluated and treated by a physical therapist directly without a prescription (or referral) for 10 visits or 30 days, whichever comes first. If you need care beyond those 10 visits or 30 days, then it is required that you obtain a prescription from a physician, podiatrist, dentist or nurse practitioner. Despite New York state allowing direct access, not all insurance companies participate and may not reimburse you for treatment without a prescription. It is strongly advised that you check with your insurance plan with regard to their policies.

PAYMENT/BILLING POLICIES

Feldman Physical Therapy, PLLC is a fee-for-service clinic. This means that payment is due at the time services are rendered and we will Not bill your insurance company. We can, upon request, provide receipts with diagnosis and treatment codes which you may choose submit to your insurance company. If further reports or documentation are requested, these will be provided. We accept cash, personal checks, and credit cards. Medicare will Not pay for services rendered at Feldman Physical Therapy. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor, healthcare provider, or fitness professional has recommended it. Right now, in your case, Medicare will not pay for our services as we are not a Participating Provider with Medicare or any other insurance company, and we only agree to work with Medicare clients for fitness, prevention, and wellness goals (which are not covered services under Medicare). You will not be able to submit for reimbursement as our services do not meet the rules set by Medicare regulations. Therefore, any receipts you may request will not include diagnosis codes and other information that Medicare claims usually posses. Signing below means that you have received and understand this notice. You may receive a copy upon request at any time.

Given you will be paying at the time of services, if your insurance company reimburses our clinic, these monies will be returned to them and a new check must be cut to you personally.

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PRIVACY POLICY

I understand that Feldman Physical Therapy, PLLC will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.

TREATMENT CONSENT

Feldman Physical Therapy, PLLC is a hands-on Physical Therapy clinic. Though highly specialized, treatment consists primarily of manual therapy techniques and treatment forms that are published or otherwise publicly known. Forms of electrical stimulation, deep tissue massage, therapeutic exercise programs, gait training, neuromuscular re-education, myofascial release, bone and soft tissue manipulation, as well as other treatment modalities may be used. Some of the hands-on treatment techniques require deep pressure which may cause bruising and periods of increased soreness which may last from 1-72 hours. Symptoms may also change and move to other parts of the body. This is not unusual and is rarely a concern, however, please ask if you have any concerns or questions. The number of treatments needed and recovery time can vary due to the age of injury, number of times injured, age of patient and many other contributing factors.

I have read and fully understand the above statements. I understand the nature of the treatments at Feldman Physical Therapy, PLLC. I authorize Justin Feldman, PT, DPT and the fully trained staff to use treatment techniques as deemed necessary for my safe and effective recovery.

I have read and completely understand the above written statements.

_____Date_____

Signature of patient/legal guardian

I also understand that Medicare will not reimburse for services rendered by Feldman Physical Therapy, PLLC

_____Date_____

Signature of patient/legal guardian

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Patient Name: _____Date:_____

Indicate below if you now have or have ever had any of the following:

Condition	**Y / N**	**Explanation with Dates**
Breathing Problems	Y / N	_____
Cancer	Y / N	_____
Dental Problems	Y / N	_____
Diabetes	Y / N	_____
High Blood Pressure	Y / N	_____
Blood Vessel Disease	Y / N	_____
Heart Attack	Y / N	_____
Pacemaker	Y / N	_____
Headaches	Y / N	_____
Hearing Aid	Y / N	_____
Joint Replacements	Y / N	_____
Metal Implants/Fragments	Y / N	_____
Arthritis	Y / N	_____
Nervous System Disorder	Y / N	_____
Visual Impairment	Y / N	_____
Allergies	Y / N	_____
Previous Surgeries	Y / N	_____
Seizures	Y / N	_____
Infectious Disease	Y / N	_____
Smoker	Y / N	_____
Fractures	Y / N	_____
Skin Condition	Y / N	_____
Open Wounds	Y / N	_____

Are you currently pregnant: Y N

List all current medications and the condition(s) for which they are being taken:

_____

_____

The above is correct to the best of my knowledge.

_____ Date: _____

Patient's Signature