

Welcome to Long Island *BALANCE Physical Therapy!!*

IMPORTANT INFORMATION, PLEASE READ!!

Thank you for choosing *Long Island BALANCE Physical Therapy!*

Please fill out the attached registration forms and bring them with you on your scheduled appointment day along with your ***prescription, photo ID, and insurance cards***. Also, please bring any medical reports you have pertaining to your condition.

You MUST arrive 30 MINUTES prior to your appointment for registration.

In order for us to give you the care you deserve, it is important to arrive on time with your registration forms completed.

We strive to keep a timely schedule and arriving prepared is beneficial to you and allows us to give every patient the time and attention necessary to begin their journey to a healthy recovery.

In addition, if you are suffering from dizziness and/or balance disorders, you **MUST** bring a **DRIVER**. If you are taking meclizine or Antivert for dizziness, please **DO NOT** take it 24 hours before your appointment.

Thank you for your cooperation.

Our location:

**ONE Hollow Lane, Suite 214
Lake Success, NY 11042**

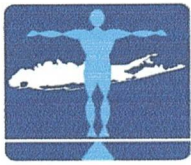
¼ mile EAST of Community Drive, on the [south, eastbound side] LIE service Road, just

Telephone number: 1-516-482-0100

Fax Number: 1-516-482-0172

We look forward to meeting you!

Dr. Attilio S. Pensavalle and the staff of L.I. BALANCE Physical Therapy.



LONG ISLAND
BALANCE
PHYSICAL THERAPY

Attilio S. Pensavalle, PT DPT

Doctor of Physical Therapy
One Hollow Lane, Suite 214
Lake Success, New York 11042
Tel: 516-482-0100 Fax: 516-482-0172

Personal Information

PLEASE COMPLETE ALL SECTIONS:

Initial Appointment Date: _____

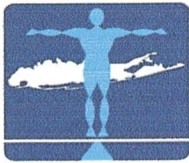
First Name:		Middle Initial:	Last Name:		Sex: <input type="radio"/> Male <input type="radio"/> Female	
Preferred Name:	Date of Birth:	Age:	Marital Status:	Employer:		
Street Address:		Apt:	City:	State:	Zip Code:	
Mobile Number:	Home Number:		Work Number:	E-Mail:		
Emergency Contact Name:	Relationship to Patient:		Contact's Home:	Contact's Cell:		
Primary Contact:	<input type="radio"/> Mobile	<input type="radio"/> Work	Appointment Reminder:		Accept E-Mail Communications:	
	<input type="radio"/> Home	<input type="radio"/> Emergency	<input type="radio"/> Text	<input type="radio"/> Call	<input type="radio"/> Yes	<input type="radio"/> No
Reason for undergoing Physical Therapy:					Date of Injury/Surgery:	
How did you hear about FYZICAL Therapy and Balance Centers in Lake Success?						
<input type="radio"/> Doctor	<input type="radio"/> Website	<input type="radio"/> Friend	<input type="radio"/> Insurance Company			
<input type="radio"/> Advertising	<input type="radio"/> Mailing	<input type="radio"/> Other: _____				
Referring Doctor:	Telephone:		Primary Care Doctor:	Telephone:		
Primary Insurance:	Member ID:		Secondary Insurance:	Member ID:		
Have you received any of the following treatments this calendar year? (If so, are you still going, and when was your last visit?)			Have you been under the care of a home health agency this year? (If so, which agency and when was your last visit?)		Are you currently receiving care from a chiropractor?	
<input type="radio"/> Physical Therapy: _____			<input type="radio"/> No <input type="radio"/> Yes:		<input type="radio"/> No <input type="radio"/> Yes:	
<input type="radio"/> Occupational Therapy: _____			_____		_____	
<input type="radio"/> Speech Therapy: _____			_____		_____	

I understand and agree (regardless of my insurance status), that I am ultimately responsible for the balance of my account for any professional services rendered. I am also responsible for recognizing insurance status including, but not limited to, benefits and allowable visits. I have read all the information on this page and certify that the information I provided is true and correct to the best of my knowledge. I also agree to notify Long Island BALANCE Physical Therapy of any changes in the above information.

Patient Name

Patient/Parent/Guardian Signature

Date



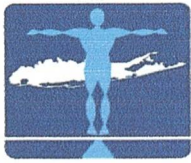
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Medical History Questionnaire (Part 1)

Patient Name:		Date of Birth: ___ / ___ / _____ Age: _____	
Reason for Therapy:		Date of Injury/Onset: ___ / ___ / _____	
Is the Reason for Therapy Accident Related? <input type="radio"/> No <input type="radio"/> Yes (If yes, please check one:) <input type="radio"/> Accident <input type="radio"/> Auto <input type="radio"/> Work <input type="radio"/> Other: _____			
Are you currently receiving any other care for the condition mentioned above? <input type="radio"/> No <input type="radio"/> Yes If yes, please list: _____			
Have you ever received therapy in the past for the condition mentioned above? <input type="radio"/> No <input type="radio"/> Yes If yes, When? _____			
Are you or have you received any physical, speech, or occupational therapy during this calendar year? <input type="radio"/> No <input type="radio"/> Yes If yes, please list name of other therapy provider: _____			
Are you or have you received any Home Health Services this calendar year? (including nursing, bathing, injections, dressing assistance, or respiratory services?) <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> If yes, please provide name of agency and date of last service: _____			
Do you or have you ever had any of the following conditions? Please Check all that apply:			
<input type="radio"/> Diabetes	<input type="radio"/> Hepatitis	<input type="radio"/> Back problems	<input type="radio"/> Head Injury/Concussion
<input type="radio"/> Heart Disease	<input type="radio"/> Tuberculosis	<input type="radio"/> Previous Fractures	<input type="radio"/> Headaches
<input type="radio"/> Heart Attack	<input type="radio"/> Asthma/Lung Disorder	<input type="radio"/> Swelling in Ankles	<input type="radio"/> Migraines
<input type="radio"/> Stroke / CVA / TIAs	<input type="radio"/> Allergies	<input type="radio"/> Hernia	<input type="radio"/> Seizures / Epilepsy
<input type="radio"/> Cancer / Tumor	<input type="radio"/> Meniere's Disease	<input type="radio"/> Osteoporosis	<input type="radio"/> Tremors
<input type="radio"/> Kidney Disease	<input type="radio"/> Visual Problem	<input type="radio"/> Weakness / Fatigue	<input type="radio"/> Anxiety
<input type="radio"/> Anemia	<input type="radio"/> High Blood Pressure	<input type="radio"/> Numbness / Tingling	<input type="radio"/> Sleep Disturbance
<input type="radio"/> HIV / AIDS	<input type="radio"/> Low Blood Pressure	<input type="radio"/> Arthritis	
Have you had any of the following tests done for this problem? If yes, check appropriate choices:			
<input type="radio"/> MRI	<input type="radio"/> Rotary Chair	<input type="radio"/> X-Rays	<input type="radio"/> ENG/VNG Caloric Testing
<input type="radio"/> ABR	<input type="radio"/> MRA	<input type="radio"/> EMG / NCV	<input type="radio"/> Audiogram (Hearing Test)
<input type="radio"/> Ultrasound / Doppler	<input type="radio"/> EKG	<input type="radio"/> CT Scan	<input type="radio"/> EEG / Stress Test
List any major surgeries and/or injuries you have had:			Dates:



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Medical History Questionnaire (Part 2)

Chief Complaint (Describe the major problem or reason you are seeing us):

Please check all the symptoms that you are currently experiencing:

<input type="checkbox"/> Dizziness	<input type="checkbox"/> Unsteadiness	<input type="checkbox"/> Weakness	<input type="checkbox"/> Ear Pain
<input type="checkbox"/> Vertigo/Spinning	<input type="checkbox"/> Unsteady Gait	<input type="checkbox"/> Unable to Focus	<input type="checkbox"/> Ear Pressure
<input type="checkbox"/> Rocking/Swaying	<input type="checkbox"/> Imbalance	<input type="checkbox"/> Unable to Concentrate	<input type="checkbox"/> Ringing/Noise in Ears
<input type="checkbox"/> Tilting	<input type="checkbox"/> Frequent Falls	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Hearing Loss
<input type="checkbox"/> Feeling "Off"	<input type="checkbox"/> Motion Sensitivity	<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Headache
<input type="checkbox"/> Blacking out/Fainting	<input type="checkbox"/> Nausea	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Migraine
<input type="checkbox"/> Lightheaded	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Neck Pain
<input type="checkbox"/> Unsteady Walking in the Dark	<input type="checkbox"/> Unsteady walking on uneven surfaces/stairs	<input type="checkbox"/> Difficulty with Head Movements	<input type="checkbox"/> Dizzy with changes in position

How much difficulty do you have hearing with a lot of background noise, i.e. groups of people? Please rate your difficulty 1-10, one being least difficult, ten being most difficult: _____

Have you seen other health care providers for this problem? If yes, please check appropriate choices and list doctor's name:

<input type="checkbox"/> Primary Care/Internist:	<input type="checkbox"/> E.R.:	<input type="checkbox"/> Neurologist:	<input type="checkbox"/> Cardiologist:
<input type="checkbox"/> ENT:	<input type="checkbox"/> Audiologist:	<input type="checkbox"/> Ophthalmologist:	<input type="checkbox"/> Other:

Have you had any falls in the last 6 months? No Yes _____ # of falls in the last 6 months

How often do you fall per month? _____ # of falls per month

Social History: (Please check all that apply)

Occupation: _____ Full-Time Part-Time Retired

Current Living Situation: House Apartment Assisted -Living Facility Other: _____

Do you have stairs in your home? No Yes If yes, how many? _____

Who do you live with? Alone Spouse/Significant Other Family Member Caregiver Supervised Setting

What are your goals with physical therapy, and what do you hope to achieve at the end of your program?

Could you be, or are you pregnant?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Do you smoke?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
At the present time, would you say that your health is:	<input type="checkbox"/> Excellent	<input type="checkbox"/> Very Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor

The information provided is correct to the best of my knowledge.

Patient/Parent/Guardian Signature: _____ **Date:** ____ / ____ / ____

Patient/Parent/Guardian (Please Print): _____ **Relationship:** _____



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RELEASE OF INFORMATION & CONSENT FOR TREATMENT

All information provided herein is true and correct. I am aware of my diagnosis and wish to receive treatment at Long Island BALANCE Physical Therapy. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I consent to rehabilitation services and diagnostic assessment. I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching and/or direct contact of a sensitive nature. I understand that this care can include an evaluation, diagnostic assessment, and treatment. No guarantees have been made to me about the outcome of this care. I give permission to Long Island BALANCE Physical Therapy to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider assignees and/or beneficiaries and all other related persons as it relates to my treatment and/or payment for services provided. I authorize Long Island BALANCE Physical Therapy to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

INITIAL: _____

ASSIGNMENT OF BENEFITS:

I authorize payment directly to Long Island BALANCE Physical Therapy for services and to bill and release payment directly to Long Island BALANCE Physical Therapy for any physical therapy and audio diagnostic services provided. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

INITIAL: _____

PAYMENT POLICY:

I understand that it is my responsibility to verify my insurance benefits for outpatient physical therapy. I also understand that Long Island BALANCE Physical Therapy will bill my insurance as a service to me, and that any charges incurred at Long Island BALANCE Physical Therapy which are not paid or adjusted by my insurance carrier(s) are my sole responsibility. I agree that if I do not have an insurance policy or if I lose my insurance policy, that I will be required to pay in full at the time of the service via cash, check, credit card, or debit card payment. I also understand that if a personal check bounces, there is a bounced-check fee of \$25.00 in addition to fees charged by my financial institution. I hereby agree to pay Long Island BALANCE Physical Therapy for the services provided to me if they are denied by my insurance company.

INITIAL: _____

NOTICE OF PRIVACY PRACTICES (HIPPA ACKNOWLEDGEMENT/CONSENT):

I hereby acknowledge that I can receive a copy of the Notice of Privacy Practices and Patient Rights & Responsibilities for Long Island BALANCE Physical Therapy upon request. In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and health care operations.

INITIAL: _____

24 HOUR CANCELLATION/NO SHOW POLICY:

I understand that my appointment is scheduled and reserved for me and that I am required to give a 24-hour cancellation notice if I am unable to make my appointment. I agree, that if I do not provide a sufficient notice of at least 24-hours, I will be charged a \$45 fee for "Less Than 24-Hour" cancellation notice. I understand that these charges will not be paid by my insurance company and that they are my responsibility to pay. I also understand that if I repeatedly neglect this policy, I may be dismissed as a patient. I hereby agree that if I do not provide adequate notice of cancellation of my appointment, I will be charged a fee for cancellation.

INITIAL: _____

PATIENT INFORMATION & DATA SHEET:

I hereby acknowledge that the information I provided on the Intake Form and the Personal Information Sheet is correct. I also acknowledge that if any changes are made to my insurance coverage, name, address, or telephone number, I will alert Long Island BALANCE Physical Therapy accordingly.

INITIAL: _____

AUTHORIZATION FOR DISCLOSURE OF PHI TO ADDITIONAL PERSONS (FAMILY, ETC.)

In addition to the authorization for release of my PHI described in the above section of this Authorization, I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

Name:	Relationship:
Name:	Relationship:
Patient/Guardian Signature:	Date:

The signature below certifies that I have read and understand the above information.

Print Patient Name:
Patient/Guardian Signature:
Date: