Rocky Hill Office
506 Cromwell Ave
Suite 103
Rocky Hill, CT 06067
Phone: (860) 721-9801

Suburban Physical Therapy & Sports Medicine Center, LLC

Cromwell Office
154 West St
Building 3, Suite C
Cromwell, CT 06416
Phone: (860) 613-0240

PATIENT RECORD

(Please fill out completely)

Appointment Date: _____

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

E-Mail Address (required): _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: Male / Female Please circle one: Single / Married / Divorced / Widowed / Separated

Employer: _____ Occupation: _____

Business Address, City and Zip Code: _____

PRIMARY INSURANCE:

Primary Health Insurance: _____ ID# _____

Person Responsible for Account: _____ Relationship: Self / Spouse / Parent

Date of Birth: _____ Responsible Party Employed By: _____

Occupation: _____ Business Address, City & Zip Code: _____

SECONDARY INSURANCE:

Secondary Health Insurance: _____ ID# _____

Person Responsible for Account: _____ Relationship: Self / Spouse / Parent

Date of Birth: _____ Responsible Party Employed By: _____

Occupation: _____ Business Address, City & Zip Code: _____

Please circle one of the following:

**Motor Vehicle Injury / **Workman's Comp. Injury / **Other Liability Injury / Not Applicable

*Date of Accident: _____ Claim Number: _____

*Insurance Company: _____

*Adjuster Name: _____ Adjuster Phone #: _____

****Attorney's Name: _____ Phone #: _____

Suburban Physical Therapy & Sports Medicine Center, LLC

MEDICAL HISTORY (*Please fill out completely)*

Primary Care Physician: _____ Phone: _____

***Have you had physical, occupational, speech therapy or chiropractic visits this year? YES NO**

***If Yes, please indicate how many visits you used this year: _____**

Current complaints/what brought you to Physical Therapy?

_____ How Long? _____

Please circle the following that best describes your current symptoms:

Ache / Pins and Needles / Burning / Stabbing / Numbness / Other

How are you able to sleep at night due to your symptoms (please circle)?

No problem sleeping / Difficulty falling asleep / Awakened by pain / Sleep only with medication

Current Medications: _____

_____

Allergies (circle all that apply): Outdoor Indoor Pet Latex Other: _____

Please circle YES or NO to the following:

YES / NO	Alzheimer's
YES / NO	Cardiovascular Disease
YES / NO	Cauda Equina Syndrome *(rare disorder that affects the spinal nerve roots)*
YES / NO	Cerebral Vascular Accident
YES / NO	Current Infection
YES / NO	Diabetes Mellitus Type 1
YES / NO	Diabetes Mellitus Type 2
YES / NO	Fibromyalgia
YES / NO	Fracture or suspected fracture
YES / NO	High Blood Pressure
YES / NO	Surgery: _____

YES / NO	History of cancer (Type: _____)
YES / NO	Huntington's
YES / NO	Immunosuppressant
YES / NO	Lupus
YES / NO	Muscular Dystrophy
YES / NO	Obesity
YES / NO	Osteoarthritis
YES / NO	Parkinson's
YES / NO	Rheumatoid Arthritis
YES / NO	Traumatic Brain Injury
YES / NO	Smoker
YES / NO	Pregnancy Possibility

EMERGENCY CONTACT LIST

Please indicate your primary physician and any family members and/or friends for emergency contacts, they will also be granted access to your medical records.

1. **Primary Care MD:** _____ Phone #: _____
2. _____ Relationship: _____ Phone #: _____
3. _____ Relationship: _____ Phone #: _____

This list will be valid for 1 year from the date signed.

Patient's Signature: _____ Date: _____

(Parent / Guardian, if patient is under 18 years of age)

Suburban Physical Therapy & Sports Medicine Center, LLC

♦ *This portion is for Medicare patients only*♦

Have you had a nurse, physical therapist or other healthcare provider from a home healthcare agency come to your house for ***any*** reason this year? *(Please circle one)* **YES** **NO**

If YES, please indicate facility and discharge date: _____

Medicare will *NOT* pay for out-patient physical therapy services if you are currently having or starting home healthcare services. **You need to be fully discharged from your home health care agency in order to start out-patient physical therapy.

MEDICARE VIEWS THE PATIENT USING HOME HEALTHCARE AS HOMEBOUND!

PROCEDURES AND FINANCIAL POLICIES

APPOINTMENTS and CANCELLATIONS

We realize unexpected situations do occur. If your schedule does change and you have to cancel your appointment, we do ask that you call in advance so that we may offer that appointment time to another patient. If you will be late, please call, as it may be necessary to reschedule your appointment time. **WE DO CHARGE A $45 FEE FOR MISSED OR CANCELLED APPOINTMENTS WITHOUT AT LEAST 24 HOURS NOTICE . This is NOT covered by your insurance!**
Please initial: _____

INSURANCE / HIPAA

This authorization or photocopy thereof, will authorize the representatives of Suburban Physical Therapy and Sports Medicine Center, LLC to release my medical information to my referring physician, insurance carrier, and/or attorney in order to facilitate the processing of my claim for physical therapy services. I also acknowledge financial responsibility for the services provided and hereby authorize payment of insurance benefits directly to Suburban Physical Therapy and Sports Medicine Center, LLC. I authorize Suburban Physical Therapy and Sports Medicine Center to file appeals for any/all claims to my insurance company on my behalf when warranted. I **have received the Notice of Privacy Practices and I have been provided an opportunity to review it.**

FINANCIAL INFORMATION

Your insurance policy is an agreement between you and your insurance company. ***It is your responsibility to verify your out-patient physical therapy benefits***. Please contact your insurance company to verify if your policy requires: prior authorization, authorization after a certain # of visits or an internal referral called in by your Primary Care Physician. **COPAYS, COINSURANCE and/or DEDUCTIBLE PAYMENTS ARE DUE AT THE TIME OF SERVICE. WE ACCEPT: Cash / Checks / VISA, Mastercard or Discover.**

****It is your responsibility to notify Suburban Physical Therapy & Sports Medicine Center, LLC of any changes to your insurance while treating at this facility.****

We bill your health insurance, auto med-pay/PIP or worker's compensation directly. *If we encounter any problems with your insurance claims, we will contact you for your assistance. **You are ultimately responsible for your bill, no matter what your insurance may be.** **If payment is not received from your insurance carrier within 30 days of your treatment, it is your responsibility to pay the outstanding balance or to pursue payment from your insurance carrier. Unpaid accounts referred to our collection agency are subject to a 30% service charge along with collection fees and attorney fees. ***CHECKS RETURNED WITH NON-SUFFICIENT FUNDS WILL BE CHARGED A $35 FEE.***

I HAVE READ AND UNDERSTAND THIS INFORMATION AND AGREE TO COMPLY WITH THE POLICIES SET FORTH HERE. THIS DOCUMENT IS VALID FOR 1 YEAR FROM THE DATE SIGNED.

Patient's Signature: _____ **Date**: _____
(Parent / Guardian, if patient is under 18 years of age)