`Comprehensive Physical Therapy Associates, PC

60 East 56th Street, 3rd Floor, New York, NY 10022
Phone: (212) 486-2848 Fax: (212) 486-2578
Comprehensivephysicaltherapy.net

General Information

Last Name_____ First Name_____
Date of Birth (mm/dd/yyyy) ____/____/____ Current Age _____
Address _____ Apt.#_____
City _____ State _____ Zip Code _____
Phone: Home _____-_____-_____ Mobile _____-_____-_____ Work _____-_____-_____
E-mail _____
How did you hear about us? _____

Referral/Diagnosis

Primacy Care Physician_____
Referring Physician _____
Diagnosis _____
Describe your symptoms/condition in your own words _____
_____
_____

Current Health/Past Medical

Do you currently or have you ever suffered any of the following:

Y□ N□ **Diabetes** Y□ N□ **Heart Condition** describe: _____
Y□ N□ **High Blood Pressure** Y□ N□ **Lung Condition** describe: _____
Y□ N□ **Dizziness** Y□ N□ **Cancer** where & when: _____
Please list any other conditions that we should know about: _____
_____

If you currently take any medications, please list their names and what they are for:

Name: _____ For: _____
Name: _____ For: _____
Name: _____ For: _____
Name: _____ For: _____
Name: _____ For: _____
Name: _____ For: _____
Name: _____ For: _____

Women: are you currently pregnant? Y□ N□

If you have ever had surgery, please list type of surgery and date:

Type of Surgery: _____ Date: _____
Type of Surgery: _____ Date: _____

Type of Surgery: _____ Date: _____
Have you had physical therapy for this condition before? If so, list when, where and the number of treatments you received _____
_____

INSURANCE INFORMATION/AUTHORIZATION TO PAY

Primary Insurance _____ Name of Insured _____
Is the insured □ Yourself, or □ Other? *If other, please specify relationship to you:*_____
Social Security/Medicare # _____
Secondary Insurance _____

Person to notify in case of emergency _____
Phone _____-_____-_____ Relationship to you _____

I request that payments be made on my behalf to Comprehensive Physical Therapy for services furnished to me by the provider. I authorize the release of any information needed to process my claims for payment.

Signature _____ Date: (mm/dd/yyyy) _____-_____-_____

Notice of Patient Information Practices

I, the undersigned, hereby acknowledge that Comprehensive Physical Therapy Associates, P.C. has provided me with a HIPPA form regarding the uses and disclosures of my health information and individual rights as a patient.

Signature _____ Date: (mm/dd/yyyy) _____-_____-_____

Notice of Cancellation Policy

Cancellations MUST be made AT LEAST 24 HOURS prior to your scheduled appointment. A $**50.00** fee will be charged for no shows or late cancellations. Please note that this fee is not reimbursed by your insurance.

I, the undersigned, hereby state that I am aware of the 24-hour cancellation policy.

Signature _____