GENERAL PATIENT INFORMATION

Date: ________________________

Name: ____

Address: ____

____

Phone: (*work*) ____________________ (*cell*) ____________________ (*home*) ____________________

Date of Birth: ____________________________ Social Security #: ___________________________

Email Address: ____

How were you referred?

____

Primary Care or Referring Physician?

____

Occupation: ____

Off work because of current episode: Yes / No Since: ___ /___ /_____

INSURANCE INFORMATION

Member ID #____

Group #____

Insured's Name and DOB ____
(*if different than patient*)

Stephanie Leaf P.T, D.P.T.
Doctor of Physical Therapy - License # 024593

39 West 14th Street, Suite 207
New York, NY 10011

HISTORY OF PRESENT COMPLAINT

Describe relevant symptoms: ____

Present since ___/___/_____ Improving / unchanging / worsening

Commenced as a result of: ______________________________ *or* no apparent reason

What makes it:

Better? ____

Worse? ____

Previous treatments: ____

X-Rays: Yes / No MRI: Yes/No Results:_____________________

MEDICAL HEALTH QUESTIONNAIRE

Circle any of the following symptoms that you have experienced in the past month:

Loss of Appetite	Headaches	Shortness of Breath	Fever
Nausea	Vomiting	Chills	Change in Bowel/Bladder
Swelling	Sweats	Bruising/Bleeding	Weakness
Lightheadedness	Rash	Dizziness	Vertigo
Numbness	Anxiety	Weight loss	

Circle any of the following that you have:

Pacemaker	Diabetes	Cancer or history of Malignancy	Osteoporosis

Recent or major surgery: Yes / No Date: ___ /___ /_____ Details: __________________________

Accidents: Yes / No Date: ___ /___ /_____ Details: ______________________________________

Unexplained weight loss: Yes / No

PATIENT AGREEMENT FORM

Thank you for electing New Leaf Physical Therapy. In order to facilitate your treatment I ask that you read and sign this agreement and authorization.

- A scheduled appointment must be cancelled at least ***24 hours in advance*** or the fee for your scheduled treatment will be due.
- You agree to be responsible for payment of all fees in full at the time of your appointment, including copayments.

You agree to pay all costs of collection, including reasonable attorneys' fees in the event of any failure to make timely payment.

________________________________ __________________

Signature of Patient Date

CONDITION AND CONSENT FOR MEDICAL TREATMENT

COOPERATION WITH TREATMENT:
I understand that I must attend my appointments as scheduled and agree to cooperate with any home program assigned to me. If I have difficulty fulfilling my program, I will discuss this with my therapist.

NO GUARANTEE AND POTENTIAL RISKS:
I understand that response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict a response to a specific modality, procedure, or exercise protocol. New Leaf PT does not guarantee what your reaction will be to a specific treatment, nor can we guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury.

I hereby authorize and request Stephanie Leaf P.T, D.P.T to provide such medical care and administer procedures and treatments as in the judgment of the New York State licensed physical therapist in attendance and deemed necessary and advisable.

________________________________ __________________

Signature of Patient Date

ASSIGNMENT OF BENEFITS TO STEPHANIE LEAF PHYSICAL THERAPY, PLLC

I _______________ hereby instruct and direct _______________ insurance company to pay by check:

STEPHANIE LEAF PHYSICAL THERAPY
39 West 14th Street, Suite 207
New York, NY 10011
646-919-0959

If my current policy prohibits direct payment to the treating therapist, and sends reimbursement directly to me (the patient) I will mail a check to the above address in the amount reimbursed.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS.

This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I__________________________ authorize the use of my signature below on all insurance submissions, insurance appeals and complaints on my behalf, and I understand that I am financially responsible for all charges whether or not paid by insurance.

_________________________________ ________________

Signature of Policy Holder Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

________________________________ ____________________

Signature of Patient Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other (Please provide specific details)

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