# Pelham Physical Medicine D&TC

*Workers Comp and No-Fault*

**First Name:** _____ **M.I.:** _____ **Last:**_____

**Address:**

_____

Number, Street & Apartment City, State & Zip Code

**Cell#**_____**Home #**_____ **Work #**_____

**Email:** _____ **SS#**_____ **DOB:** _____

**Marital Status:** _____**Sex:** _____**Occupation:** _____

**Ethnicity:**_____ **Race:** _____

**Primary Care Physician**:_____ **Phone:**_____

**Emergency Contact Information:**

**Name:** _____ **Relationship:** _____**Phone:**_____

**How did you hear about us?**

- o I've been treated in this clinic before
- o Referred by current/former patient _____
- o Internet/google_____
- o Hospital / Doctor List _____
- o Walk-in _____
- o Others _____

**Name of Doctor/Person who recommends therapy:** _____

**Reason for visit:**_____

**Please list all allergies:**_____

**Please list any current medical problem you have:**_____

**Please list any surgeries:** _____

**Do you smoke?** **Y□ N□** **How much?** _____

**Do you drink alcohol/beer? Y□ N□** **How much?** _____

**Consent For Treatment:**

I, the undersigned hereby authorize Pelham Physical Medicine, and its designated employees to administer prescribed treatment, diagnostic tests, as necessary. I further certify that no guarantees or assurances have been made to me regarding the results that might be obtained.

**NAME:** _____ **DATE:** _____

# Pelham Physical Medicine D&TC

**Patient Acknowledgements Pelham Physical Medicine D&TC Office Policies and Insurance Information**

**Co-payments and Deductibles:**
Payment is required for all services at the time they are rendered. All applicable co-payments and deductibles will be collected at time of service. We reserve the right to charge an additional $10.00 if co-payments are not paid at the time of service. In the event that your account is turned over to collections, interest and /or a collection fee at the provider's current rate will be charged on all balances that are past due. Your signature below signifies your understanding and agreement with this policy.

**Financial Responsibility:**
I understand and agree that all health and insurance policies are an arrangement between the insurance carrier and myself. I authorize that the insurance company shall remit by cheque all payments directly to PPM, Inc. I further grant PPM, Inc. power of attorney to endorse any checks remitted in my name for the purpose of applying that amount to my account.

I further acknowledge that I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment.

**HIPPA POLICY:**
Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act. This Federal Law prohibits any staff member of Pelham Physical Medicine, Inc. from discussing appointments, medication, test results or treatment plans with anyone other than the patient. Often, this causes difficulty for some patients who would like family members or caretakers to obtain information for them. If you would like to permit someone to Discuss your medical condition, confirm appointments or obtain results for you, please indicate their name(s) below. Only these individuals will be provided with information. Should you wish to update the names provided below, please ask the receptionist for a HIPPA form.

Approved person(s) Name(s): _____Relationship: _____

Do we have your permission to call the below:

| | | |
|---|---|---|
| Leave a message on your answering machine at home? | Yes□ | No□ |
| Email and text of any financial responsibilities | Yes□ | No□ |
| I have received a copy of the Notice of Privacy Practices related to Health Insurance Portability and Accountability Act of 1996. (HIPPA) | Yes□ | No□ |

**Signature:** _____ **Date:** _____

**Signature of Guardian for Minor Child:**_____ **Date:**_____

# Pelham Physical Medicine D&TC

## Notice of Privacy Acknowledgement

I have received, read and fully understand this "Notice of Privacy Practices" and also understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), that I have certain rights pertaining to the release and sharing of my medical information. My medical information can only be shared with my full authorization and written consent and understanding that it will serve my best interests regarding my health and treatment. I have the right to restrict or deny access to my medical information as I see fit. I am also aware that you are not required to agree to my restrictions but if you do agree you are to abide by the restriction

**Patient Name:** _____

**Signature:** _____

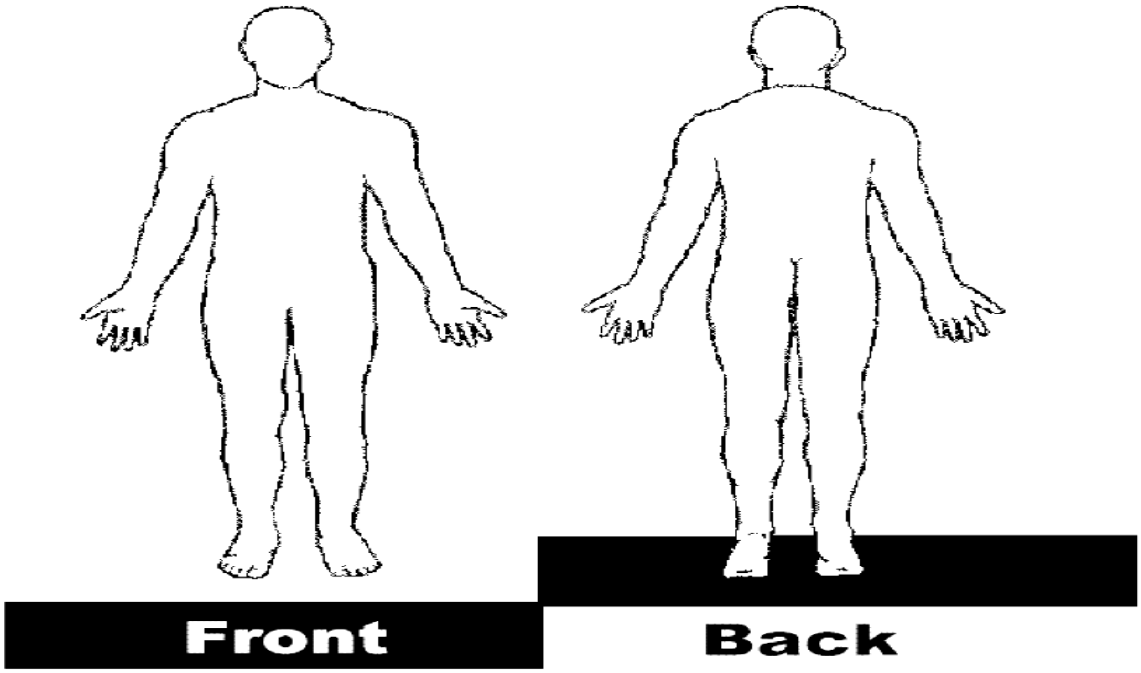
**Date:** _____

**Witness:** _____

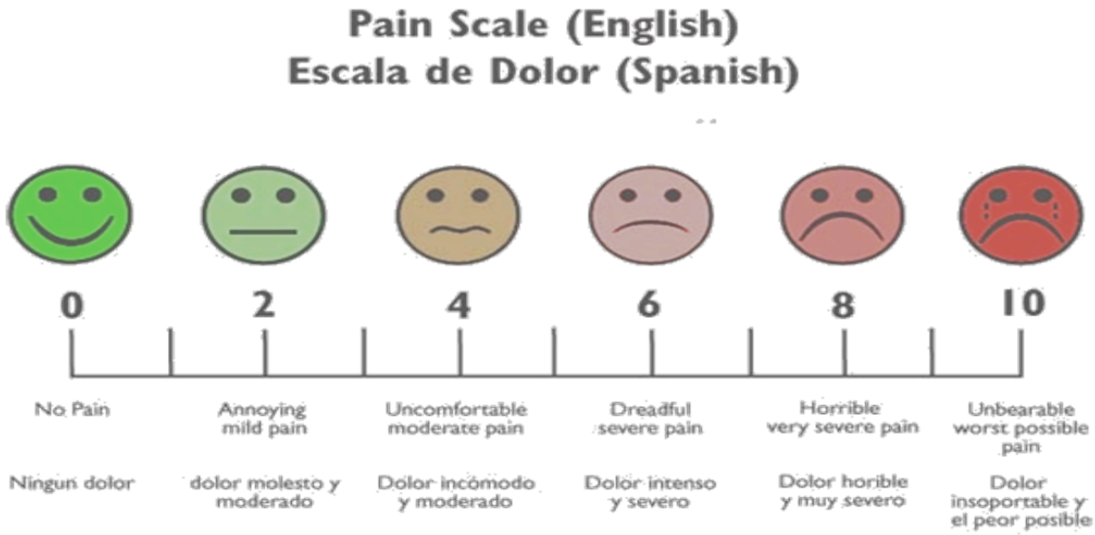
□HIPPA Policy given to patient

**Initials:** _____ **Date:** _____

**Circle where you have pain. // Dibuje un círculo adonde usted siente el dolor.**




**Which number is your pain level // Cual numero es su dolor?**



**Appointment Policy**

At Pelham Physical Medicine D&TC, we value your time and strive to provide the best care possible. To ensure efficient scheduling and accommodate all patients, please review our appointment policy:

1. **Cancellations & Rescheduling** – If you are unable to make your scheduled appointment, please notify us as soon as possible. Advance notice allows us to offer the appointment to a patient on our waiting list.

2. **No-Show Policy** – We do not accept walk-ins. If you miss two (2) consecutive physical therapy appointments without notice, you will be removed from the schedule. To resume treatment, you must call to reschedule, and we cannot guarantee availability at your previous time slot.

3. **Doctor Appointments** – If you fail to attend your scheduled doctor's appointment, we cannot guarantee an appointment for the following week. Rescheduling will be based on the provider's availability.

4. **Late Arrivals** – Patients arriving late may have their appointment shortened or rescheduled based on provider availability. Please arrive on time to ensure you receive the full benefit of your session.

5. **Emergency Cancellations** – We understand that emergencies happen. If you need to cancel due to an emergency, please inform us as soon as possible so we can assist you in rescheduling appropriately.

We appreciate your cooperation in adhering to this policy, which helps us provide timely and effective care to all patients. If you have any questions, please contact our office at 718-823-3900 or email at Info@pelhamrehab.com.

**NAME:** _____ **DATE:** _____

# Pelham Physical Medicine D&TC

## MEDICATION LIST

**Pharmacy Name:**_____

**Pharmacy Phone:**_____

Please include all prescriptions, as well as all Over the Counter medications Include all Vitamins/Supplements taken on a regular basis.

Allergies to Any Medication**:**

_____

| Medication Name | Dose | Frequency |
|---|---|---|
| **1**. | | |
| **2.** | | |
| **3.** | | |
| **4.** | | |
| **5.** | | |
| **6.** | | |

**Consent for Medication History**

I hereby authorize Pelham Physical Medicine D&TC to access my medication history through secure electronic health record systems for the purpose of providing safe and effective treatment.

**NAME:** _____ **DATE:** _____

## Consent for Release of Information

I hereby authorize the periodic release of the above information to Pelham Physical Medicine, Inc. as often as necessary to plan/provide care and treatment. I understand that the information to be released is confidential and protected from disclosure. I also understand that I have the right to cancel my permission to release information at any time.

My consent to release information to Pelham Physical Medicine, Inc. will expire when I am no longer receiving services from Pelham Physical Medicine, Inc., or one year from this date, whichever occurs first.

Printed Name: _____

Signature: _____

Date: _____

## CONSENT FOR MEDIA RELEASE

By signing below I authorize Pelham Physical Medicine to photograph and record me, and any work performed to me by this facility. I understand the photos will be used for informational and instructional purposes only and will not be used to generate a profit. I understand photos or videos will be used on platforms such as Instagram, Facebook, and our website. I will not be compensated nor will I seek compensation for the photos or videos. I release the organization from responsibility should a third party violate the terms of this release.

Printed Name: _____

Signature: _____

Date: _____

# Pelham Physical Medicine D&TC

**Name:**_____ **DOB:**_____

**Date of Injury**: _____

**History:**

1- Describe briefly how the accident/injury occurred:

_____

_____

2- What area(s) of your body was/were injured?

_____

_____

3- What medical care occurred the day of the accident or injury?

_____

_____

**Work History:**

1- What is your current occupation?

_____

2- Are you currently working?

_____

3- Was time lost from work due to injury:

_____

4- If YES give dates From_____ to _____

5- Any restricted duty?

_____

**Name:**_____ **DOB:**_____

**Present Complaints:**

List all symptoms and complaints related to this injury:

_____

_____

_____

**Treatment:**

List all treatments rendered- doctors seen, test you have had, please indicate specialty of each doctor and approximate dates(s) seen:

_____

_____

_____

Treatments- include different types such as physical therapy, surgery etc.:

_____

_____

Tests you have had or are scheduled for (MRI EMG etc.):

_____

_____

Please list all medications given for this accident/injury:

_____

_____