STROMA
PHYSICAL THERAPY

152 W25th St Suite 601
New York, NY 10001
212-255-5531(t)
212-255-5377(f)
www.stromapt.com

New Patient Intake & History

Name: _____

DOB: _____ (mm/dd/yy) Height: _____ Weight: _____

SSN: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____ Home: _____ Cell: _____

Employer: _____Occupation: _____ Name of referring doctor/PCP: _____

Emergency Contact and Phone Number

Name: _____ Tel: _____ Relationship: _____

Reason for Visit (What is your major complaint?)

How long have you had this problem?

Have you had a similar condition in the past? Was it treated?

Are you pregnant? Y N Are you wearing a pacemaker? Y N

Describe any other medical conditions:

List Surgical History:

List current Medications (or provide a list): Dosage: Frequency:

How did you hear about Stroma Physical Therapy? _____

Health Insurance and Portability and Accountability Act: The health providers and staff at Stroma Physical Therapy are trained in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to ensure the privacy, confidentiality and security of patient information. If you would like to receive a copy of Stroma Physical Therapy HIPAA Privacy Notice, please do so by requesting copy from the receptionist.

Assignment: I request that payment of authorized insurance benefits be made on my behalf to Stroma Physical Therapy LLC, for any service furnished by the healthcare providers. I authorize any holder of medical information about me to release to the insurance company and its agents any information needed to determine these benefits payable for related services. I understand that this is an out of network provider and that I am responsible for my co-insurance and deductible. I will endorse any checks forwarded to me from my health insurance company as payment for the services that I have received, when such is the case. I clearly understand and agree that all services rendered to me are charge directly to me and that I am personally responsible for payment.

Sexual Misconduct/Harassment Policy: I acknowledge that I read and understand the Sexual Misconduct/Harassment Policy and agree to abide by its terms and conditions.

_____ _____

Signature Date

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Insurance Reimbursement Agreement and Cancellation Policy

Our Administrative staff will work with you and your insurance carrier to co-ordinate your care and ensure proper and timely reimbursement of all claims.

Please review the following and initial and sign where indicated:

1) I agree to supply Stroma Physical Therapy with all of my current Insurance Carrier's information and will inform the clinic of any changes, additions or terminations to my plan in a timely manner. _____ Initial

2) In the event that my Insurance Carrier does not make the expected and verified payment I understand that I am responsible for all incurred charges and agree to make a payment agreement with Stroma Physical Therapy to cover those charges. _____ Initial

3) I agree that Stroma Physical Therapy can appeal on your behalf to your insurance company if requested. _____Initial

4) I authorize the release of any medical or other information necessary to process an outstanding claim for service. _____ Initial

5) I authorize payment of insurance benefits to be paid directly to Stroma Physical Therapy. _____ Initial

6) Copays are flat fees. Coinsurance is a % of the cost for health service. As an **out-of-network provider** we are required by law to charge coinsurance, for this reason we have a mandatory coinsurance policy. However, due to financial hardships Stroma works with individuals prior to their first visit regarding their coinsurance. I agree to pay for services obtained from Stroma as agreed prior to first visit _____Initial.

7) In the event that my Insurance Carrier does not remit assigned benefits directly to Stroma Physical Therapy I understand and agree that I will be fully financially responsible for those payments. I also agree to forward any payments I receive from my Insurance Carrier for our services within 10 days of receipt. Insurance payments not forwarded to Stroma Physical Therapy will be subject to interest after 10 days. _____ Initial

8) I understand that I will be charged a $75.00 fee for missed appointments or for appointments cancelled with less than 24h notice. If a Late/Cancelled appointment is made up within the same week the $75.00 fee will be waived. _____ Initial

9) I understand that I may receive correspondence via email regarding insurance, payments and some PHI. I consent that I allow my email to be used for this correspondence. _____Initial

Signed: _____ Date: _____

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Mark an X in the box next to all of the symptoms you currently have or have had in the past.

GENERAL

Past	Current	
☐	☐	Poor appetite
☐	☐	Excessive appetite
☐	☐	Insomnia
☐	☐	Fatigue
☐	☐	Fevers
☐	☐	Night sweats
☐	☐	Sweat easily
☐	☐	Chills
☐	☐	Localized weakness
☐	☐	Poor coordination
☐	☐	Change in appetite
☐	☐	Strong thirst
☐	☐	Other _____

SKIN AND HAIR

Past	Current	
☐	☐	Rashes
☐	☐	Hives
☐	☐	Itching
☐	☐	Eczema
☐	☐	Pimples
☐	☐	Dryness
☐	☐	Tumors/lumps
☐	☐	Other _____

HEAD AND NECK

Past	Current	
☐	☐	Fainting
☐	☐	Neck stiffness
☐	☐	Enlarged lymph glands
☐	☐	Headaches
☐	☐	Concussions
☐	☐	Dizziness
☐	☐	Other _____

EARS

Past	Current	
☐	☐	Infection
☐	☐	Ringing
☐	☐	Decreased hearing
☐	☐	Discharge
☐	☐	Other_____

EYES

Past	Current	
☐	☐	Blurred vision
☐	☐	Visual changes
☐	☐	Poor night vision
☐	☐	Spots
☐	☐	Cataracts
☐	☐	Glasses/Contacts
☐	☐	Eye inflammation
☐	☐	Other _____

CARDIOVASCULAR

Past	Current	
☐	☐	High blood pressure
☐	☐	Low blood pressure
☐	☐	Blood clots
☐	☐	Palpitations
☐	☐	Fainting
☐	☐	Phlebitis
☐	☐	Chest pain/Angina
☐	☐	Irregular heartbeat
☐	☐	Cold hands/feet
☐	☐	Swelling of hands/feet
☐	☐	Pacemaker
☐	☐	Other _____

RESPIRATORY

Past	Current	
☐	☐	Asthma
☐	☐	Bronchitis
☐	☐	Frequent colds
☐	☐	Pneumonia
☐	☐	Cough
☐	☐	Coughing blood
☐	☐	Production of phlegm
☐	☐	Emphysema
☐	☐	Shortness of breath
☐	☐	Chronic obstructive pulmonary disease
☐	☐	Other _____

GASTRO-INTESTINAL

Past	Current	
☐	☐	Nausea
☐	☐	Vomiting
☐	☐	Diarrhea
☐	☐	Belching
☐	☐	Blood in stools/black stools
☐	☐	Bad breath
☐	☐	Rectal pain
☐	☐	Hemorrhoids
☐	☐	Constipation
☐	☐	Pain or cramps
☐	☐	Indigestion
☐	☐	Gall bladder disorder
☐	☐	Gas
☐	☐	IBS
☐	☐	Heartburn
☐	☐	Other _____

GENITO-URINARY

Past	Current	
☐	☐	Kidney stones
☐	☐	Pain on urination
☐	☐	Frequent urination
☐	☐	Blood in urine
☐	☐	Urgency to urinate
☐	☐	Unable to hold urine
☐	☐	Other _____

FEMALE

Past	Current	
☐	☐	Frequent urinary tract infections
☐	☐	Frequent vaginal infections
☐	☐	Pain/itching of genitalia
☐	☐	Genital lesions/discharge
☐	☐	Pelvic inflammatory disease
☐	☐	Abnormal pap smear
☐	☐	Irregular periods
☐	☐	Painful menstrual periods
☐	☐	Premenstrual syndrome
☐	☐	Abnormal bleeding
☐	☐	Menopausal syndrome
☐	☐	Breast lumps
☐	☐	Other _____

NEUROLOGICAL

Past	Current	
☐	☐	Seizures
☐	☐	Tremors
☐	☐	Numbness or tingling of limbs
☐	☐	Concussion
☐	☐	Pain
☐	☐	Paralysis
☐	☐	Other _____

PSYCHOLOGICAL

Past	Current	
☐	☐	Depression
☐	☐	Anxiety/Stress
☐	☐	Irritability
☐	☐	Emotional/Psychological issues
☐	☐	Mania/bipolar
☐	☐	PTSD
☐	☐	Other _____

MALE

Past	Present	
☐	☐	Pain/itching of genitalia
☐	☐	Genital lesions/discharge
☐	☐	Impotence
☐	☐	Weak urinary stream
☐	☐	Lumps in testicles
☐	☐	Prostatitis
☐	☐	Other _____

NOSE, THROAT, AND MOUTH

Past	Present	
☐	☐	Nose bleeds
☐	☐	Sinus infection
☐	☐	Hay fever or allergies
☐	☐	Recurring sore throats
☐	☐	Grinding teeth

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☐ ☐ Difficulty swallowing

Notice of Advice for Patients Requesting Physical Therapy Treatment
Under New York State's Direct Access Law

Under New York's Direct Access Law, you may be treated by a physical therapist without a prescription. You may be evaluated and/or treated for up to 10 visits or 30 days, whichever comes first. Please note that treatment under New York's Direct Access Law is not applicable to worker's compensation, no-fault, or Medicare coverage. I have been informed of the possibility that physical therapy treatment may not be covered by my healthcare insurer without the referral of a physician, dentist, podiatrist, or nurse practitioner, but may be a covered expense, if treatment was rendered pursuant to such referral. I understand that I am responsible for any unpaid balance.

Patient Name: **Signature:** **Date:**

Consent to Physical Therapy Evaluation and Treatment

I hereby consent to evaluation and/or treatment of my condition by a licensed physical therapist employed by or under contract with Stroma Physical Therapy. I understand that any adult or minor can request a chaperone at any time. The physical therapist has fully explained to me the nature and purposes of the procedures, evaluation and course of treatment, and has witness my signature of this consent in his or her presence.

Patient Name: **Signature:** **Date:**

Credit Card Signature on File Form

In order to simplify the satisfaction of your fee per visit, Stroma Physical Therapy enables you to make your payments by credit card. To facilitate processing and permit you to authorize payments via phone, Stroma Physical Therapy requests that you sign below so that we can maintain your signature on file.

Please note that at no time will payments be processed without your awareness and prior consent.

I, the undersigned, acknowledge that Stroma Physical Therapy is hereby authorized to charge my credit card for payments authorized by me without obtaining any additional signatures.

Patient signature:

Date:

Credit Card Number: _____ **Exp Date:** _____

Credit Card (please circle): AMEX MASTERCARD VISA CVV Code: _____