Zuppa Physical Therapy, PC

801 Route 50, Suite 1, Burnt Hills, NY 12027
p: 518-952-7780 f: 1-888-370-2441
www.ZuppaPT.com

Patient Information

Name: _____
Last First MI

Address: _____
Street City State Zip code

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

Age: _____ DOB: _____ Height: _____ Weight: _____

Sex: Male / Female *(please circle)* email address: _____

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed

Emergency Contact: _____ Phone: _____

Employer Name: _____ Occupation: _____

How did you hear about Zuppa Physical Therapy? _____

_____

Brief Description of Injury or Surgery _____

_____

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Parent or Responsible Party *(if different than patient)*

Name: _____ Relationship to Patient: _____

Address: _____
Street City State Zip code

Insurance Information:

Name of Policy Holder: _____ DOB: _____ Phone #: _____

Address: _____ Employer: _____

Primary Insurance: _____

ID #: _____ Group #: _____

Secondary Insurance: _____

ID #: _____ Group #: _____

No-Fault Insurance: _____ Date of Accident: _____ Claim #: _____

Workers Compensation: _____ Date of Accident: _____ Claim #: _____

Consent to Treatment:

I consent to treatment provided by Zuppa Physical Therapy, PC. I recognize that I have a condition requiring medical care and further acknowledge that I am aware and affirm that no guarantees have been made to me concerning treatment by Zuppa Physical Therapy, PC.

_____ _____

Patient / Guardian Signature Date

Cancellation and No-Show Policy

- **We require 24 hours notice in the event of canceling a scheduled appointment.** When canceling an appointment please have an alternative time in mind in order to maintain the prescribed number of treatments for that week.
- **There is a $35.00 charge for a cancellation without proper notice or a No-Show.** As a courtesy to the patient we will waive the first cancellation without proper notice / no-show offense. In the event of a second offense we will expect payment prior to being seen for a subsequent visit.

Please note that the above policies are in place because of the individualized care that Zuppa Physical Therapy, PC provides. Thank you for your cooperation.

I have read and understand the above policies, and agree to the terms.

_____

Patient name (print)

_____ _____

Signature of patient or responsible party Date

Financial Policies and Agreement

Payment is due when services are rendered unless other arrangements are made in advance. If payments are not promptly received, an 18% per annum interest penalty will be added to your balance, until paid in full. If account is sent to collections, any fees associated with said collections agency will be added to your balance.

Payment which have not been paid in full after 90 days of your service date will be turned over to our collection agency, with any fees or expenses assumed through the collections agency or court added to your balance.

If applicable, you are responsible for obtaining any necessary referral / prescription. You will need to present the referral / prescription at the time of your initial evaluation. In the event that you are seen (with your acknowledgement) without the proper referral / authorization as required by your insurance carrier, you will be responsible for payment of all fees. In the event that your insurance carrier deems any services unauthorized or not medically necessary, payment for these services are your responsibility.

Explanation of financial responsibility without insurance coverage: I understand that if I am seen (with my acknowledgement) by Zuppa Physical Therapy, PC without health insurance coverage, I am ultimately responsible for the balance on my account for any professional services rendered.

Commitment to make co-payment: In order to comply with the rules and regulation of each health insurance company, co-payment must be paid at the time of service rendered.

Benefit Assignment: You assign all medical benefits to Zuppa Physical Therapy, PC including health insurance, Medicare, auto insurance, workers' compensation or other insurance plans. You authorize Zuppa Physical Therapy, PC to release your medical records in order to process your claims.

Voluntary Termination of Care: If you care is suspended or you terminate your care at anytime, your portion of all charges for professional services will be immediately due and payable to Zuppa Physical Therapy, PC.

Financial Policies and Agreement continued:

Method of Payment: We accept cash, check, and card payments. There will be a $35 charge for returned checks. Copayments and billing statement prices are reflective of cash or check payments. Card payments are 3.75% higher.

I have read and understand the above financial policy and agreement, and agree to the terms therein.

_____ _____

Signature of patient or responsible party Date

HIPAA Privacy Notice
Notice of Privacy Practices for Zuppa Physical Therapy, PC

Zuppa Physical Therapy, PC is dedicated to keeping your health records confidential. This notice describes how your Protected Health Information may be utilized.

1.) We keep records of your care in order to provide you with quality care.

2.) We use your health information ONLY for; treatment purposes, billing purposes, for the operation of the practice, as required by law, to avert a serious threat to health, safety, to send to military departments as required by law, to send to workers' compensation programs, to send to law enforcement agencies as required by law.

3.) Your rights regarding the health information we maintain about you include the rights to; inspect your health information used to make decisions about your care by submitting a written request, amend information that you feel is incorrect by submitting a written request, request a list of accounting of any disclosures of your information not listed above, request a restriction of limitation on health information that we disclose by submitting a written request.

4.) We may use your name, address, phone number, e-mail and your records to contact you with appointment reminders, information regarding physical therapy, and information regarding Zuppa Physical Therapy, PC.

If you have any questions regarding your HIPAA Privacy rights, please contact Angelo Zuppa at 518-952-7780 or Angelo@ZuppaPT.com. Please note a more detailed HIPAA notice is available upon request.

I have read and understand the HIPAA Notice of Privacy. I authorize and consent to the use and disclosure of my protected health care information as outlined above.

_____

Patient name (print)

_____ _____

Signature of patient or responsible party Date

DATE:_____

MEDICAL SCREENING FORM

Circle YES or NO...

Have you or any immediate family member ever been told you have:

	Self		Family	
Cancer?	☐ Yes	☐ No	☐ Yes	☐ No
Diabetes?	☐ Yes	☐ No	☐ Yes	☐ No
High Blood Pressure?	☐ Yes	☐ No	☐ Yes	☐ No
Heart Disease?	☐ Yes	☐ No	☐ Yes	☐ No
Angina/chest pain?	☐ Yes	☐ No	☐ Yes	☐ No
Stroke?	☐ Yes	☐ No	☐ Yes	☐ No
Osteoporosis?	☐ Yes	☐ No	☐ Yes	☐ No
Osteoarthritis?	☐ Yes	☐ No	☐ Yes	☐ No
Rheumatoid arthritis?	☐ Yes	☐ No	☐ Yes	☐ No

In the past 3 months have you had or do you experience:

A change in your health?	☐ Yes	☐ No
Nausea/vomiting?	☐ Yes	☐ No
Fever/chills/sweats?	☐ Yes	☐ No
Unexplained Weight Change?	☐ Yes	☐ No
Numbness or tingling?	☐ Yes	☐ No
Changes in appetite?	☐ Yes	☐ No
Difficulty swallowing?	☐ Yes	☐ No
Changes in bowel or bladder function?	☐ Yes	☐ No
Shortness of Breathe?	☐ Yes	☐ No
Dizziness?	☐ Yes	☐ No
Upper respiratory infection?	☐ Yes	☐ No
Urinary tract infection?	☐ Yes	☐ No

Patient Information:

NAME: _____

Phone: _____

PLEASE COMPLETE THE BACK SIDE OF THIS FORM

Circle YES or NO...

Do you have a history of:

Allergies/ Asthma?	☐ Yes	☐ No
Headaches?	☐ Yes	☐ No
Bronchitis?	☐ Yes	☐ No
Kidney disease?	☐ Yes	☐ No
Rheumatic Fever?	☐ Yes	☐ No
Ulcers?	☐ Yes	☐ No
Sexually transmitted disease?	☐ Yes	☐ No
Seizures?	☐ Yes	☐ No

Are you currently:

Pregnant?	☐ Yes	☐ No
Depressed?	☐ Yes	☐ No
Under Stress?	☐ Yes	☐ No

Are your symptoms: (check one)

☐ Getting Worse ☐ The same ☐ Improving

How are you able to sleep at night? (check one)

☐ Fine ☐ Moderate Difficulty ☐ Only with medication

Check all that apply...

Do you have a problem with... (Check all that apply)

☐ Hearing ☐ Vision

☐ Speech ☐ Communication

Do you or have you in the past smoked tobacco? ☐ YES ☐ NO

If yes, _____ Packs **X** _____ Years.

Last tobacco use_____

Do you drink alcoholic beverages? ☐ YES ☐ NO

If yes, how many drinks do you routinely have per week?

_____/week.

Date of last physical examination _____

List medications currently using:

_____

_____

Please use the diagram below to indicate where you feel symptoms right now. Use the following key to indicate the different types of symptoms.

KEY: Pins and Needles = 00000 **Stabbing: /////**
Burning = XXXXX **Deep Ache = zzzzz**