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 *(please circle)*

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 and check. There is a $30.00 charge for any returned checks.

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**