

Raymond N. Cecora, P.T., D.P.T., M.S.

Nicole J. Brock, D.P.T.

Travis Tennie, D.P.T.

John Bianchini, D.P.T

Louis Mastrangelo, P.T.A

Jarrett Parks, P.T.A

# PATIENT INFORMATION SHEET

Name\_ \_Date of Birth Address\_ City \_Zip HomePh#\_ Cell Ph# \_Email

# You will be receiving a reminder of your appointments. Please provide your preferred method for receiving these reminders. Please CIRCLE ONLY ONE: Home Cell Email

Employer Address \_Ph# Emergency Contact\_ Ph#\_ Relationship Marital Status

# PRIMARY CARE DOCTOR REFERRING DOCTOR

Who can we thank for referring you? Physician Friend \_Other

# HAVE YOU RECEIVED PHYSICAL THERAPY AT ANOTHER FACILITY IN THE PAST YEAR? YES / NO

**If yes, dates and location:**

**INSURANCE**

**Primary** Name of Insured Date of Birth\_ \_Relationship: self \_\_\_\_ spouse\_\_\_\_ child Social Security #\_ Employer \_Ph# **Secondary** Name of Insured Date of Birth\_ \_Relationship: self\_\_\_\_spouse\_\_\_\_\_child Social Security #\_ Employer \_Ph#

# Worker’s Compensation / No Fault

Date of Accident Insurance Carrier Claim# \_Contact Person Ph#\_ I hereby authorize payment of medical benefits to Raymond N. Cecora, P.T.,D.P.T.,M.S.,C.E.A.S. for services rendered by him in person or a licensed physical therapist or physical therapist assistant employed by him. I understand that I am financially responsible for any balance not covered by my insurance. I certify that the information given by me in applying for payment is correct. I authorize all records on request. I request all authorized benefit payments be made on my behalf.

# PLEASE NOTE: IF YOU DO NOT HAVE A REFERRAL FROM YOUR PHYSICIAN, PODIATRIST, NURSE PRACTICIONER OR DENTIST OR YOU HAVE BEEN RECEIVING HOME CARE, YOUR PHYSICAL THERAPY VISITS MAY NOT BE COVERED BY INSURANCE AND THEREFORE THE PATIENT’S RESPONSIBILITY.

Patient Signature\_ Date\_

Parent/Guardian Signature Date\_

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**PERSONAL HISTORY**

Name\_ \_Date

Date of Onset of Current Symptoms

# Please List

Past Medical History

Past Surgical History and Date

Do you have a Pacemaker, Debifrillator?

Medical Testing (MRI, CT Scan, X-Rays)

Where\_ Date\_

History of falls\_

Medications

Prescription

Over the counter

# Park.jpg

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# Park.jpgAUTHORIZATION FORM

 , hereby authorize Park Physical Therapy to use and or disclose in protected health information pursuant to the Notice of Privacy Practice are posted in this office. I have been given the opportunity to review and or receive a copy of these privacy practices.

This authorization shall be in force and effect unit such time that I give notification requesting the termination of this authorization.

I understand that I have the right to evoke this authorization in writing at any time by sending such written notification to the attention of Linda Cecora, Privacy Officer at 5500 Merrick Road, Massapequa, NY 11758. I understand that a revocation is not effective to the extent that Park Physical Therapy relied on the use of disclosure of the protected health information.

I understand that I have a right to:

Inspect or copy the protected health information to be used or disclosed as permitted under federal or state law to extent the state law provides greater access rights and/or refuse to sign this authorization.

Signature of Patient or Personal Representative Date

Name of Patient or Personal Representative

Person(s) we can discuss your care with other than your Referring Physician including spouse, significant other, and children:

# THIS AUTHORIZATION IS BEING REQUESTED BASED ON THE NEW FEDERAL REGULATIONS THAT BECAME EFFECTIVE OCTOBER 2003 FOR ALL HEALTH CARE PROVIDERS.