PACT

Physical Therapy Intake Form

Personal Information	
First Name:	Last Name:
Address:	
Phone:	Email:
DOB (mm/dd/yy) / /	Sex:
Who referred you?	

History	
Exercise frequency:	Exercise Type(s):
Do you smoke?	Have you ever smoked?
How often?	
Are you pregnant?	Do you have a Pacemaker?
Allergies:	
What medications are you currently using?	
Previous complaints / surgeries:	
Previous diagnoses / medications:	

Complaint	
What is your major complaint?	
Start date:	Possible Cause:
Symptoms:	
Previous doctors seen for complaint:	
Previous treatment for complaint:	
Symptom-Aggravating Factors:	
Symptom-Relieving Factors:	
Time of Day Symptoms are Best:	

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Time They are Worst:				
Current Duration of Pain	❑ Intermittent		❑ Constant	❑ With Certain Motions
Current Level of Pain	❑ Mild	❑ Moderate	❑ Severe	❑ Excruciating
Is your pain getting better or worse?				
Have you had this injury before?				

Do you have any of the following today? (Check all that apply)

❑ AIDS / HIV	❑ Anemia	❑ Chemical Dependency	❑ Arteriosclerosis
❑ Arthritis	❑ Asthma	❑ Blood Clots	❑ Bone Infection
❑ Cancer	❑ Angina	❑ Circulation Problems	❑ Depression
❑ Diabetes	❑ Epilepsy	❑ High / Low Blood Pressure	❑ Heart Problems
❑ Hemophilia	❑ Eye Infection	❑ Joint / Bone Infection	❑ Liver Problems
❑ Lung Issues	❑ Multiple Sclerosis	❑ Musculoskeletal Problems	❑ Pneumonia
❑ Stroke	❑ STD	❑ Tuberculosis	❑ Urinary Infection

Mark Areas of Discomfort

Signature

Date

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Notice of Advice for Patient's Requesting Physical Therapy Treatment under New York's Direct Access Law

Thank you for choosing PACT, PLLC as your physical therapy provider.

You have decided to utilize our services under New York's "direct access to Physical therapy" law, which is effective November 23, 2006. Under this law, you may be treated by a physical therapist without a prescription or referral. You may be evaluated and/or treated by a licensed physical therapist 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, Medicare or No-Fault coverage. If you are seeking care under Worker's Compensation, Medicare or No-Fault coverage, physical therapy MUST be prescribed by your physician to be covered.

We are required to inform you that this treatment may not be paid by your insurance carrier if you have not obtained a prescription for physical therapy, and a referral for physical therapy, if required by your insurance, from a physician, dentist, podiatrist or nurse practitioner licensed to practice in New York State. We are also required to inform you that this treatment may be paid by your insurance carrier if you **were to have** obtained a valid prescription and referral, if a referral is required by your insurance carrier.

We require co-payment or co-insurance payments to be made at time of treatment. We will bill your carrier for the balance but in the event they do not pay due to a missing prescription or referral, you will be responsible for the entire unpaid balance.

I have read this form and acknowledge that I am about to obtain physical therapy treatment for myself, or my minor child, under New York's Direct Access law. I understand that my insurance carrier may not pay for these services since I have not obtained a prescription and/or referral from a New York State licensed physician, dentist, podiatrist or nurse practitioner. I understand and accept that this will make me personally liable for today's charges as well as future treatment under the Direct Access Law.

Name of Insurance Carrier: _____

Insurance ID # _____

Date Treatment will begin: _____/_____/_____

_____ _____

Name of Patient - Please print Address of Patient

_____

Name of Guardian - Please print

_____ _____/_____/_____

Signature of Patient or Guardian Date

_____ **133 E 55th St., 2nd Fl., New York, NY, 10022**

Therapist Name Therapist Address

_____ _____/_____/_____

Therapist Signature Date