



**Jeffrey J. Sanoian, PT PC**  
**PHYSICAL THERAPY**  
 16 Squadron Boulevard  
 Suite 102 Suite 102  
 New City, NY 10956

**PATIENT INFORMATION**

Jeffrey J. Sanoian PT PC

DATE: \_\_\_\_\_

NAME	HOME PHONE	CELL PHONE
ADDRESS – City, State, Zip	WORK PHONE	DATE of BIRTH
EMAIL	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W
EMPLOYER	PHONE	
EMERGENCY CONTACT	PHONE	

PRIMARY INSURANCE		
INSURANCE CARRIER	ID #	
SUBSCRIBER NAME	RELATION to PATIENT	DATE of BIRTH
WC/NO FAULT INSURANCE	CASE #	
CASE MANANGER	PHONE #	
INSURANCE ADDRESS		
Is patient covered by additional insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO		
INSURANCE CARRIER	ID #	
SUBSCRIBER NAME	RELATION to PATIENT	DATE of BIRTH

**Consent for Care and Treatment**

I, the undersigned, do hereby agree and give my consent to **Jeffrey J. Sanoian, PT PC** and all its health care professionals using its facility to furnish medical care and treatment to (please print) \_\_\_\_\_ considered necessary and proper in diagnosing or treating his/her physical and mental condition.

Patient/Guardian/Responsible Party \_\_\_\_\_ Date \_\_\_\_\_  
 (Parent/Guardian signature required if under 18 years of age)

OFFICE USE ONLY	
Referring Physician	NPI
Phone	DX
Body part being treated	DATE of INJURY
Authorized number of visits	Has deductible been met?

Jeffrey J. Sanoian, PT PC  
PHYSICAL THERAPY  
16 Squadron Boulevard  
Suite 102  
New City, NY 10956



Jeffrey J. Sanoian PT PC

(845) 639-1181 • Fax: (845) 639-4685  
[jeffsanoianpt@hotmail.com](mailto:jeffsanoianpt@hotmail.com)

**Patient Medical Intake Form**

Name: \_\_\_\_\_ Referring Physician \_\_\_\_\_  
Occupation: \_\_\_\_\_ Date of first doctor visit for this injury: \_\_\_\_\_  
Last date worked due to injury: \_\_\_\_\_ Date returned to work after this injury: \_\_\_\_\_

Is an attorney involved in this case?  Yes  No  
Have you had a surgery for this injury?  Yes  No      Number of surgeries: 1 2 3 4 Other \_\_\_\_\_  
Type of surgery: \_\_\_\_\_  
Where did the surgery take place? \_\_\_\_\_

Are you currently taking any prescription or non-prescription medications?  Yes  No

**List of Medications**

Anti-inflammatories \_\_\_\_\_  
Muscle Relaxants \_\_\_\_\_  
Pain medication(s) \_\_\_\_\_

Describe your current problem and how it began: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

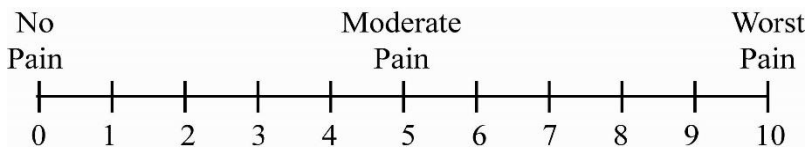
Onset date/Surgery date? \_\_\_\_\_

**How often are your symptoms present?**  
 Constantly (76-100% of the day)       Occasionally (26%-50% of the day)  
 Frequently (51-75% of the day)       Intermittently (0-25% of the day)

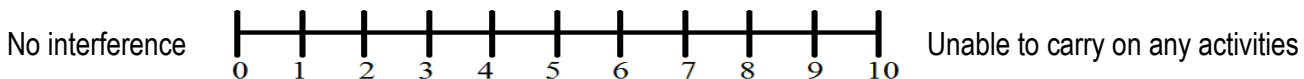
**Describe the nature of your pain:**  
 Sharp  Dull ache  Numb  Shooting  Burning  Tingling

**How is your condition changing?**  
 Getting better  Not changing  Getting worse

**Current complaint (how do you feel today):**



**In the past week, how much has your pain interfered with your daily activities (e.g. work, social activities, or household chores)?**





**Have you had any of the following medical or rehabilitative services for this episode/injury?**

Chiropractor	<input type="checkbox"/> Yes <input type="checkbox"/> No	CT Scan	<input type="checkbox"/> Yes <input type="checkbox"/> No
EMG/NCV	<input type="checkbox"/> Yes <input type="checkbox"/> No	General Practitioner	<input type="checkbox"/> Yes <input type="checkbox"/> No
Massage Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	MRI	<input type="checkbox"/> Yes <input type="checkbox"/> No
Myelogram	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neurologist	<input type="checkbox"/> Yes <input type="checkbox"/> No
Occupational Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthopedist	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Podiatrist	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emergency Room Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	X-Rays	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other			

**To the best of your knowledge, do you now have or have you ever had ANY of the following?**

High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood in stool/Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart attack or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest pains/Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio/Muscle disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy/Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Severe or frequent headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	TMJ disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Infectious disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fibromyalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chronic Fatigue Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No
Concussion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lyme's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chronic Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anxiety/Panic attacks	<input type="checkbox"/> Yes <input type="checkbox"/> No	Night Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Unexplained weight loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer/Tumors/Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke/TIA	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis/Swollen Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Patient's/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Jeffrey J. Sanoian, PT PC**  
PHYSICAL THERAPY  
16 Squadron Boulevard  
Suite 102  
New City, NY 10956



**Jeffrey J. Sanoian PT PC**

(845) 639-1181 • Fax: (845) 639-4685  
[jeffsanoianpt@hotmail.com](mailto:jeffsanoianpt@hotmail.com)

**Consent for Care and Treatment**

I, the undersigned, do hereby agree and give my consent to **Jeffrey J. Sanoian, PT PC** and all its health care professionals using its facility to furnish medical care and treatment to (please print) \_\_\_\_\_ considered necessary and proper in diagnosing or treating his/her physical and mental condition. These interventions are in accordance with the State Practice Act for their respective professions.

**Patient/Guardian/Responsible Party** \_\_\_\_\_ **Date** \_\_\_\_\_

**Assignment of Insurance Benefits/Release of Information**

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payers to **Jeffrey J. Sanoian, PT PC**. I also request payments of government benefits either to myself or to the party who accepts assignment. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

**Patient/Guardian/Responsible Party** \_\_\_\_\_ **Date** \_\_\_\_\_

**Financial Policy Statement**

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not permit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payment made, you will be made responsible for the amount of money refunded to your insurance company. In the event that your company establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit same to **Jeffrey J. Sanoian, PT PC**.

*The above may not apply for those patients that are considered Worker's Compensation. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges rendered to you.*

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

**I UNDERSTAND MY RESPOSIBILITY FOR THE PAYMENT OF MY ACCOUNT.**

**Patient's/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Jeffrey J. Sanoian, PT PC**  
PHYSICAL THERAPY  
16 Squadron Boulevard  
Suite 102  
New City, NY 10956



**Jeffrey J. Sanoian PT PC**

**(845) 639-1181 • Fax: (845) 639-4685**  
[jeffsanoianpt@hotmail.com](mailto:jeffsanoianpt@hotmail.com)

### **Physical Therapy Attendance Policy**

**Jeffrey J. Sanoian, PT PC** is dedicated to patient satisfaction and the highest quality care while attempting to accommodate your treatment schedule. Therefore, we provide reserved appointments for each patient in order to minimize waiting and assure the continuity of treatment. Your consistent attendance is vital to your recovery. Please adhere to the duration and frequency of your physical therapy treatment per your physician's prescription.

Cancellations, along with no-shows, decrease our ability to accommodate the scheduling needs of other patients. Your full cooperation is required with the following policy:

- If you are unable to keep a scheduled appointment, please contact our office 24 hours in advance or email us at our website [www.JeffPT.com](http://www.JeffPT.com)
- If you acquire 3 or more cancellations or no – shows, your therapist may refer you back to your physician before scheduling another appointment or may choose to discharge you from therapy and report this to your physician.
- A charge of \$15.00 may be assessed for all missed appointments (except if our office is notified 24 hours in advance).

### **Referral and Prescription Policy**

Insurance regulations require that referrals and prescriptions be presented to your physical therapist at the time of your visit.

It is your responsibility to keep track of the number of visits allowed and the valid period of referral and prescription. Failure to do so may result in treatment that was not authorized by your insurance carrier, and any changes incurred for these unauthorized visits would be your full responsibility.

### **Payment Policy**

Copays or fees for service are due and payable at the time of service. Noncompliance may cause an interruption in your treatment schedule.

**I acknowledge and understand the above:**

**Patient's/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_