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

PATIENT INFORMATION

DATE: _____

NAME – Last, First, Middle			MARITAL STATUS ☐ M ☐ S ☐ D ☐ W
ADDRESS – City, State, Zip + 4			EMAIL
HOME PHONE	CELL PHONE	DATE of BIRTH	GENDER ☐ M ☐ F
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? ☐ YES ☐ 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?

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

Patient Medical Intake Form

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

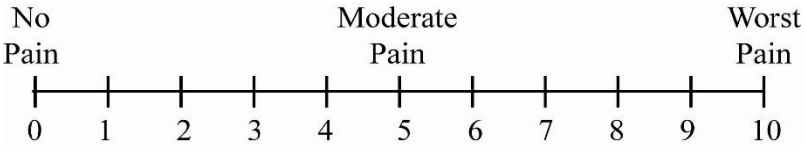
List of Medications

Anti-inflammatories _____
Muscle Relaxants _____
Pain medication(s) _____

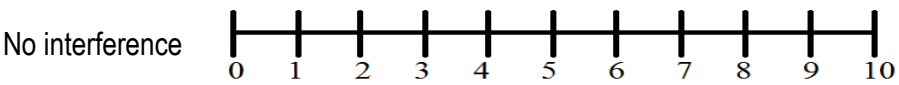
Describe your current problem and how it began: _____
_____
_____
Onset date/Surgery date? _____

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)?



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

Chiropractor	☐ Yes ☐ No	CT Scan	☐ Yes ☐ No
EMG/NCV	☐ Yes ☐ No	General Practitioner	☐ Yes ☐ No
Massage Therapy	☐ Yes ☐ No	MRI	☐ Yes ☐ No
Myelogram	☐ Yes ☐ No	Neurologist	☐ Yes ☐ No
Occupational Therapy	☐ Yes ☐ No	Orthopedist	☐ Yes ☐ No
Physical Therapy	☐ Yes ☐ No	Podiatrist	☐ Yes ☐ No
Emergency Room Care	☐ Yes ☐ No	X-Rays	☐ Yes ☐ No
Other			

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

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

Patient's/Guardian Signature: _____ **Date**: _____

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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**: _____

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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
- 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**: _____