G & B Physical Therapy, P.C.

Phone: 607-756-9886 Fax: 607-756-8939

Last Name: _____ First: _____ Middle: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Other: _____
Emergency Contact: _____ Phone: _____
Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Other Sex: ❑ Male ❑ Female
Email: _____ Age: _____
Social Security Number: _____ Date of Birth: _____
Employer: _____ Occupation: _____

Work, Auto Accident or School Related? ❑ Yes **(fill in next section)** ❑ No

Worker's Comp Required Info / Motor Vehicle / School Injury Info

Date of Injury/Accident: _____
Employer/School: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Employed: ❑ Full Time ❑ Part Time ❑ Retired ❑ Student
Carrier: _____
Carrier Address: _____
City: _____ State: _____ Zip: _____
Carrier Phone: _____ Case Manager: _____
Claim Number: _____ **WCB #:** _____
Description of Incident: _____

_____

Have you notified your employer? ❑ Yes ❑ No
Have you been treated for this same work-related injury at another PT office? ❑ Yes ❑ No

Insurance Information:

Insurance Company: _____
Policy Number: _____ Group Number: _____
Subscriber Name: _____ Subscriber DOB: _____
Relationship to Patient: _____

Guarantor: *(If patient is a minor, please list the person responsible for payment)*

Name:_____DOB:_____

Address:_____City:_____State:_____Zip:_____

Relationship to Patient: _____

Informed Consent for Physical Therapy Services:

Physical therapy is a patient care service that is provided in order to manage a wide variety of conditions. Services are provided to individuals of all ages regardless of gender, color, ethnicity, creed, national origin, or disability. The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them. Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. Goldwyn and Boyland Physical Therapy, PC does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury. It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment. I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care. I authorize the release of my medical information to appropriate third parties.

Patient Name_____

Responsible Party(Parent/ Gaurdian)_____

Signature_____ Date_____

Assignment of Insurance Benefits and Financial Responsibility Guarantee:

I hereby assign any and all insurance benefits due and payable to me/us by my insurance policy for services rendered to Goldwyn and Boyland Physical Therapy, PC. I further understand and agree that this assignment is non-revocable. I authorize Goldwyn and Boyland Physical Therapy, PC to release to my insurance carrier the paperwork necessary for processing payments related to physical therapy claims. I authorize any holder of my personal medical information to release to Goldwyn and Boyland Physical Therapy, PC any required information needed to determine insurance benefits. If required by my insurance carrier, I agree to provide all pertinent information necessary for completion of my treatment plan(s) and for the issuance of timely payments. I understand that I personally guarantee to be financially responsible to pay Goldwyn and Boyland Physical Therapy, PC for any and all charges not covered by this assignment. All co-pays/(including deductible payments) must be paid at the time of service in accordance with the contracted insurance carrier agreements. If my insurance carrier sends me payment for services incurred in this office, I understand that I am required to deliver the full payment to Goldwyn and Boyland Physical Therapy, PC immediately upon receipt.

Payments may be made by cash, check, or credit card.

- ☐ I have read this document and I execute it with full knowledge, understanding, and acceptance of its contents.

Patient Name_____

Responsible Party(Parent/ Gaurdian)_____

Signature_____ Date_____

Privacy Practices Acknowledgement (Hipaa Consent) **Full Notice of Privacy Practices listed below*

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Pratices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.
I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient Name_____

Responsible Party(Parent/ Gaurdian)_____

Signature_____ Date_____

PHYSICAL THERAPY, P.C.

Greg Streblow, PT, MPS, CSCS, YFS
Kelly Brunscheen, PT, DPT, CSCS
Susan Ives, PTA, MS, AT-Ret
Tyler Dancause, PT, DPT, ATC

Appointment No Show & Cancellation Policy

Thank you for trusting your care to Goldwyn & Boyland Physical Therapy, P.C. When you schedule an appointment with Goldwyn & Boyland Physical Therapy, P.C., we set aside enough time to provide you with the highest quality care. No-Shows and last minute cancellations have begun to negatively impact our office. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment No Show & Cancellation Policy below:

- Effective **August 1, 2023** any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours notice** will be considered a no show and charged a **$25.00 fee** for each occurrence.

- If a **third** no show or cancellation/reschedule without 24 hour notice should occur the patient may be **discharged** from Goldwyn & Boyland Physical Therapy, P.C and their remaining appointments will be cancelled.

- Any new patient who fails to show for their initial visit will not be rescheduled.

- The fee is charged to the patient, not the insurance company, and is **due at or before the time of the patient's next office visit**. If all visits are cancelled, you will be invoiced the fee.

- As a courtesy, when time/technology allows, we make reminder calls/texts for appointments. If you do not receive a reminder call or text, the above policy will remain in effect. With that being said, often we don't receive messages/texts from the teleminder until the day of the scheduled appointment these will count as no-shows/late notice cancellation.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our office and let us know. You may contact Goldwyn & Boyland Physical Therapy, P.C 24 hours a day, 7 days a week at the number below. Should it be after regular business hours Monday through Friday, or a weekend, please leave a message.

Goldwyn & Boyland Physical Therapy, P.C 607-756-9886

o **I have read and understand the Appointment No Show & Cancellation Policy and agree to its terms.**

_____ _____
Signature (Parent/Legal Guardian) Relationship to Patient

_____ _____ _____
Printed Name Date of Birth Date

Goldwyn & Boyland Physical Therapy, P.C.

Patient's Name: _____ Date of Birth: _____

Condition for which you are receiving therapy: _____

Date when condition began: _____

Medical History – Have you ever been diagnosed as having any of the following conditions?

Condition:	No	Yes (Currently)	Yes (Previously – list dates)
Anemia			
Ankylosing Spondylitis			
Arterial Blockage in Legs			
Thrombosis (Blood Clot)			
Other Circulation Disorder			
Asthma			
Bone or Joint Infection			
Kidney Infection			
Urinary/Bladder Infection			
Other Infection			
Cancer			
Tumor			
Chemical Dependency (e.g. Alcoholism)			
Depression			
Diabetes (Insulin Dependent)			
Diabetes (Not Insulin dependent)			
Emphysema			
Endometriosis			
Epilepsy/Seizures			
Gout			
Headaches (More than 1 per week)			
Heart Attack			
Heart Valve Condition			
Hepatitis			
High Blood Pressure			
Hyperhyroid (High)			
Hypothyroid (Low)			
Immune System Disorder			
Multiple Sclerosis			
Osteoarthritis (Wear & Tear Arthritis)			
Osteoporosis			
Pelvic Inflammatory Disease			
Pneumonia			
Rheumatoid Arthritis			
Stroke			
Tuberculosis			
Ulcers			
Urinary Incontinence			

Other illnesses diagnosed by physician (please list): _____

_____

_____

Surgical History

	No	Within 12 Months	More Than 12 Months Ago (List Dates)
Abdominal Surgery			
Heart Surgery			
Pacemaker			
Hernia			
Bone or Joint Surgery			

Other Surgeries (Please List): _____

_____

Medications

During the past week, have you taken any of the following medications **not prescribed** by a physician:

	No	Yes
Advil, Motrin, Aleve, Ibuprofen		
Aspirin		
Tylenol/Acetaminophen		
Antacids		
Laxatives		
Decongestants/Antihistamines		
Tagamet, Zantac, Pepcid		
Herbal Medicines		

Other Medications (Please List): _____

_____

During the past week, have you taken any of the following medications, **prescribed** by a physician:

	No	Yes
Anti-inflammatory (e.g. Motrin, Naprosyn)		
Aspirin		
Tylenol/Acetaminophen		
Muscle Relaxers		
Pain Relievers (e.g. Darvocet, Vicodin)		
Blood Pressure Medications		
Diuretics (fluid pills) other than blood pressure		
Stomach Ulcer Medication		
Heart Medications (other than blood pressure)		
Antibiotics		
Thyroid Medication		
Asthma Medication		
Antidepressant Medication		
Insulin		
Seizure Medication		
Decongestants/Antihistamines		

Other Medications (Please List): _____

_____

Do you smoke? ❑ No ❑ Less than 1 pack/day ❑ More than 1 pack/day Are you pregnant? ❑ No ❑ Yes

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

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

G&B
PHYSICAL THERAPY, P.C.

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Notice of Possible Non-Payment by Third Party Payors

Physical Therapy services when rendered under Direct Access Law provision of New York State may not be covered under your insurance plan. If a physician's referral has been made for the same physical therapy your insurance may cover those services.

By signing below I understand and accept the above statement in full, and I have received a copy for my records.

Patient Signature_____ Date_____

Printed Name _____