CAYUGA HAND & PHYSICAL THERAPY, P.C.

903 Hanshaw Road
Ithaca, NY 14850

www.cayugahandpt.com
(607) 229-2165

Leon Wolff, MPT, CHT
Physical Therapist and Certified Hand Therapist

Patient Intake Information

Name: _____ Date of Birth: _____/_____/_____Age: _____

Place of Employment: _____Occupation: _____

Emergency Contact Person and Phone: _____

Regarding your present condition for which you are attending physical therapy

Referring Physician: _____

Onset date of Original injury/condition: _____/_____/_____

Surgery Date: _____/_____/_____

Were you independent with activities at home and in the community/work prior to your injury or surgery?
_____Yes _____No

If not, briefly explain:
_____
_____
_____
_____
_____

What are your goals related to your condition and physical therapy?

_____
_____
_____
_____

Have you had or do you have any of the following? Please circle YES or NO

History of falls	YES	NO	How many in past 12 months?
Osteoarthritis	YES	NO	
Rheumatoid arthritis	YES	NO	
Cardiovascular disease	YES	NO	
High Blood Pressure	YES	NO	
Chest pain/Angina	YES	NO	
Cardiac pacemaker	YES	NO	
Diabetes Type 1	YES	NO	
Diabetes Type 2	YES	NO	
Allergies- seasonal	YES	NO	

Allergies Latex	YES	NO	
Allergies- other	YES	NO	
Osteoporosis	YES	NO	
Previous fractures, joint injury or dislocation	YES	NO	
Previous surgeries	YES	NO	
Diagnostic tests for present injury	YES	NO	X-ray, MRI, NCS, EMG?
Current over the counter medication and dosage	YES	NO	
Current prescription meds and dosage	YES	NO	
Herbals	YES	NO	

Vitamins/minerals/dietary supplements and dosage	YES	NO	
History of cancer	YES	NO	
Dizziness	YES	NO	
Shortness of breath	YES	NO	
Tingling or numbness in arms/hands or legs	YES	NO	
History of seizures	YES	NO	
Kidney problems	YES	NO	
Fibromyalgia	YES	NO	
Tobacco use	YES	NO	
Do you drink alcohol	YES	NO	How often/how much?
Have you had a joint replacement	YES	NO	

Other conditions not mentioned above? _____

Patient (or Guardian) Signature_____ Date_____

CONSENT & ACKNOWLEDGEMENT FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing below, you consent to the use and disclosure of your protected health information *by Cayuga Hand & Physical Therapy, P.C.* and staff, for treatment, payment and health care operations. You have the right to request that we restrict our uses or disclosures of your protected health information, which we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions*. However, if we agree to further restrictions, they are binding on us*. Finally, you have the right to revoke the consent in writing, except to the extent that we have taken action in reliance on it.

*My *"*protected health information*"* means health information, including my demographic information i.e. name, address, insurance company, age and other related information collected from me and created or received by my physical therapist, another health care provider and a health plan. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

This information will not be sold or released to outside entities for marketing purposes.

_____ _____

Signature/Date Name of Patient or Guardian (Please Print)

PHOTO AUTHORIZATION

I, _____, authorize Cayuga Hand & Physical Therapy P.C. to photograph/video my hand/upper extremity for purposes of

1. Documentation of status and home program development
2. Teaching
3. Publication

Initial_____ Date _____

E-MAIL Correspondence Authorization

With permission our Electronic Medical Record (EMR) will send notices for appointments.
Cayuga Hand & Physical Therapy P.C. uses video and photos and typed instructions for patient education and home programs. I authorize the use of my email to send my home programs. Neither my face identity nor name will be transmitted in this correspondence. The email to send this information is:

_____

Initial _____ Date_____

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Authorization For Treatment

Physical therapy is a patient care service provided in response to a wide range of medical care needs of outpatients of all ages, regardless of gender, color, race, creed, national origin or disability. For information on Certified Hand Therapists (CHT) please refer to www.htcc.org (Hand Therapy Certification Commission)

The purpose of Physical Therapy is:

- To treat disease, injury and disability by evaluation, examination, testing and use of rehabilitative procedures, joint and soft tissue mobilizations, exercise, and physical agents including, but not limited to, mechanical devices, heat, cold, air, light, water, electricity and sound in the aid of diagnosis or treatment.
- To obtain for the physician, information needed in diagnosis and evaluation of patients.
- To prevent or minimize residual physical and disability.
- To aid the patient in achieving maximum potential within his capabilities.
- To accelerate convalescence and reduce the length of the functional recovery.

All procedures will be thoroughly explained to you before they are performed. There are certain inherent risks with Physical Therapy treatment because you may be asked to exert effort and perform activities with increasing degrees of difficulty, which could cause an increase in your current level of pain or discomfort of an aggravation to your existing injury. There is also a possibility that you could experience new injury, but this risk is small. You will be able to control any procedure by stopping if you feel any increase in pain or discomfort.

The Physical Therapist will take every precaution to ensure that you are protected from any hazardous situation. You will never be forced to perform any procedure that you do not wish to perform. You may also be instructed in doing exercises and performing procedures such as local application of heat at home. This home program is tailored to your condition and lifestyle.

Based on the above information I agree to cooperate fully and to participate in all Physical Therapy procedures and to comply with the plan of care as it is established.

NOTICE TO PATIENTS: For personal safety, do not use any equipment without a staff member present or do not progress exercises without direction of the Physical Therapist.

Patient Name (printed)_____

Patient Signature_____
Date_____

Legal Guardian_____
Date_____

Physical Therapist Signature_____
Date_____

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_____

Initial _____ Date_____

Insurance File Record

Name of Patient: _____ DOB: _____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____Cell:_____

Insurance Company Name: _____

ID or Policy # _____ Group: _____

Policy Holder's Name: _____ DOB: _____

Policy Holder's Employer: _____

Policy Holder's Address: _____

Relationship to Patient: _____Self _____ Spouse _____ Child _____ Other

Referred to our office by: _____

Is Condition related to an accident? _____ YES _____ NO

Worker's Compensation Insurance

Date of Injury:_____ Date of Surgery:_____

Referring Provider:_____

Insurance Carrier's name:_____

Employer Name:_____ Employer Phone:_____

Claim #:_____

Case Manager Name:_____

Case Manager Phone:_____ Fax:_____

Does Patient have other Health Insurance? _____ YES _____ NO

Insurance Name: _____ Policy #_____

Policy Holder's Name: _____ DOB: _____

Lifetime Insurance Authorization

Practice name **Cayuga Hand & Physical Therapy, P.C.**

Provider: Leon Wolff, MPT, CHT

I authorize the release of any medical information necessary to process claims.

I also authorize payments under my insurance programs to be made directly to the above provider for any services furnished to me.

This authorization will remain in effect indefinitely unless revoked by me in writing.
I further permit copies of the authorization to be used in place of the original.

_____ _____

Patient Signature (or responsible party) Patient Name (or responsible party)

_____

Date

Practice Care Management Group (PCMG) performs billing services for Leon Wolff PT PC. Please be assured that Practice Care Management Group has signed a confidentiality clause with Leon Wolff, PT PC and all billing matters will be kept strictly confidential. Also, full payment for services rendered by Leon Wolff, PT PC is due within 3 months of the date the service is rendered, unless other arrangements are made in advance. Failure to comply with this agreement gives the provider the right to turn outstanding charges over to a private collection agency. My signature on this form verifies that I understand this agreement and will comply with the same.

_____ _____

Signature (Insured or Authorized Person) Date

FOR BILLING QUESTIONS CALL: PRACTICE CARE MANAGEMENT GROUP (PCMG) AT (800) 313-5023