HARRISON PHYSICAL THERAPY, P.C.
1505 Route 52, Suite 12 · Fishkill, NY 12524 · Phone: (845) 896-3750 · Fax: (845) 896-5728

PATIENT INFORMATION

Name: _____ Today's Date: _____
Last First Middle Initial

Address: _____
Street City State Zip

Bill to: _____
Street City State Zip

Phone: ( )_____ E-mail: _____ Soc. Sec. #: ____-____-____

Marital Status: Single ____ Married ____ Other ____ Birth Date: _____ Patient Sex: M F

****

Occupation: _____ Status: Employed ___ Retired ___ Student ___ Not Working ___

Employer Name: _____ Phone: ( ) _____

Address: _____
Street City State Zip

****

Primary Care Physician: _____ Referring Physician: _____

Date of Injury: _____ Is this injury Job-Related? Y N or Automobile Accident-Related? Y N

How did you first hear about Harrison Physical Therapy? _____

In case of emergency, contact: _____ Phone: ( ) _____

****

Primary Insurance: _____ Phone: ( )_____

Address: _____
Street City State Zip

Insured's Name: _____ Relation to Insured: _____

Group # _____ ID # _____ Attn: _____

Secondary Insurance: _____ Phone: ( ) _____

Address: _____
Street City State Zip

Insured's Name: _____ Relation to Insured: _____

Group # _____ ID # _____ Attn: _____

I hereby certify that all information is true to the best of my knowledge, and I am responsible for all charges incurred for these services. Late payments may be subject to 1.5% finance charges. I hereby authorize the release of any medical information necessary to process my claim and authorize my insurance company to pay Harrison Physical Therapy, P.C. directly for services rendered.

Patient's Signature (Guardian if patient is under 18): _____ Date: _____

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Patient Name: _____ Date: _____

Indicate below if you now have or have ever had any of the following:

Condition	Y / N	Explanation with Dates
Breathing Problems	Y / N	
Cancer	Y / N	
Dental Problems	Y / N	
Diabetes	Y / N	
High Blood Pressure	Y / N	
Blood Vessel Disease	Y / N	
Heart Attack	Y / N	
Pacemaker	Y / N	
Headaches	Y / N	
Hearing Aid	Y / N	
Joint Replacements	Y / N	
Metal Implants/Fragments	Y / N	
Arthritis	Y / N	
Nervous System Disorder	Y / N	
Visual Impairment	Y / N	
Allergies	Y / N	
Previous Surgeries	Y / N	
Seizures	Y / N	
Infectious Disease	Y / N	
Smoker	Y / N	
Fractures	Y / N	
Skin Condition	Y / N	
Open Wounds	Y / N	

Are you currently pregnant: Y N

List all current medications and the condition(s) for which they are being taken:

_____

_____

_____

The above is correct to the best of my knowledge.

_____ Date: _____

Patient's Signature

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WELCOME

Harrison Physical Therapy, P.C. is dedicated to providing high quality, individualized care to each of our patients in an environment that makes rehabilitation a truly enjoyable and positive experience. Each patient is educated about their condition, while being instructed in a personalized, progressive therapy program designed to produce significant measurable improvement in their condition, achieve their personal goals, and attain their highest level of function.

Your doctor has prescribed physical therapy, which is an ongoing process that requires regular attendance to be optimally effective. Consequently, not attending scheduled sessions may inhibit your ability to attain your full rehabilitation potential.

We at Harrison Physical Therapy, P.C. believe that clear communication with your prescribing physician is essential to optimize your rehabilitation. Please notify us at least one week in advance of any visit to your prescribing physician, so that we can perform a reevaluation and send a progress note.

APPOINTMENT POLICY

Please arrive on time for your appointments so that you can receive your full scheduled treatment. If you arrive later than 15 minutes past your scheduled appointment time, your treatment may be shortened or cancelled.

Please notify us at least 24 hours in advance if you need to cancel your appointment. Failure to do so may result in a $25 charge.

INSURANCE RESPONSIBILITY

Although we are familiar with most of the larger insurance plans, each policy is individual with regard to its specific provisions. It is the patient's responsibility to verify their percentage of payment per visit, any co-payments or deductibles, and limits of visits per calendar year. As a service to our patients, we at Harrison Physical Therapy, P.C. will be glad to submit your insurance claims for you, but you are responsible for any portion not paid by your insurance. If you need any assistance in this matter, please feel free to speak with the office staff.

I have read and understood, and agree to comply with policies stated above.

I hereby give Harrison Physical Therapy, P.C. permission to perform physical therapy as prescribed by my physician on myself or my child (if applicable).

_____ Date: _____

Signature of patient (or guardian if under 18)

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FINANCIAL POLICY

Harrison Physical Therapy, P.C. is dedicated to providing you with the highest quality of care, and is willing to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to us. Please consult the office staff if you have any questions about our fees, financial policy, or your responsibility.

As a service to our patients, we at Harrison Physical Therapy, P.C. will be glad to submit your insurance claims for you. However, you are responsible for any portion not paid by your insurance. Payment is due for services at the time services are rendered. We will collect all copayments and deductibles at the time of your visit.

If a check is returned for insufficient funds, you will be charged the bank fee in addition to the amount of the check. After the insurance company has paid their portion of your claim, should your financial responsibility be unpaid after 90 days, the account will be turned over to a collection agency and you will be responsible for the balance of your bill as well as any collection charges incurred.

I understand and agree to comply with the Financial Policy as explained above.

_____ Date: _____

Signature of patient (or guardian if under 18)