

Lindenhurst Physical Therapy

Restore your quality of life with complete, hands-on, results-oriented physical therapy.

When pain, injury, lost function or impaired motion makes it difficult to enjoy life or perform necessary daily functions, it can leave you feeling frustrated, fearful, even depressed.

At **Lindenhurst Physical Therapy**, we understand. We've helped tens of thousands of people – from infants to seniors with all types of physical challenges – regain function and get back to enjoying life again. To achieve your goals, you need a physical therapist who gives you the time, one-on-one attention and hands-on care you deserve.

Lindenhurst Physical Therapy is one of the largest, most respected physical and aquatic therapy practices in the area. Our personalized approach includes advanced and proven techniques, state-of-the-art equipment, a unique saltwater aquatic therapy program and comprehensive services. All delivered at multiple locations throughout Nassau and Suffolk counties to give you the best results possible.

At **Lindenhurst Physical Therapy** you will experience the caring, compassion, and high credentialed physical therapy that can make a big difference in your life. We can relieve your pain and restore your function with state-of-the-art hands-on therapy and all the latest equipment.

NOTICE OF PATIENT INFORMATION PRACTICES

This notice describes how medical information about you may be used or disclosed and how you can get access to information, please review it carefully. If you have any questions about this policy give us a call.

LINDENHURST PHYSICAL THERAPY LEGAL DUTY

It is the legal duty of Lindenhurst Physical Therapy to protect the confidentiality of your personal health information. We are required to provide you with this notice which outlines our policies and procedures.

USES AND DISCLOSURES OF HEALTH INFORMATION

Lindenhurst Physical Therapy, hereafter referred to as the Practice, uses your personal health information (PHI) in order to provide treatment to you, to be able to obtain payment for your treatment, to perform administrative activities within the practice, and for being able to determine the quality of care that is provided to you. PHI is all the personal information that can identify you: your name, address, telephone number, social security number, health policy number, etc. For example, we may use your PHI to call you to remind you about an appointment or to contact your insurance company for payment, speak to your Doctor about your program, or just call you into the treatment area from the waiting room.

The practice may use your PHI without prior authorization when we are required to do so by law, if there is a public health concern, if you have a communicable disease, if we believe that there is abuse or neglect, for research studies, for legal proceedings, for law enforcement, if a crime occurs in the Practice's office, if an emergency occurs, to funeral directors and coroners, for military activity and national security, and for worker's compensation.

It is policy of Lindenhurst Physical Therapy to get a signed authorization from you prior to releasing your PHI. You have the right to either agree or object to the release of your information. If you agree and sign a written authorization, you have the right to take back the authorization at a later date if you choose to. If you are not actually present, or unable to agree or disagree, to the disclosure of information, the Practice can then use it's professional judgment to decide if the disclosure is in your best interest.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to inspect and ask for a copy of your personal health information at any time. You have the right to ask us to make changes or corrections in your information. The Practice does not have to comply with your request. You have the right to file a disagreement with the Privacy Officer.

You may request a list of all the disclosures that we have made of your PHI after April 14, 2009 for any reason other than for treatment, billing, or administrative activities of the practice.

You also have the right to ask in writing that the Practice not disclose your PHI except when authorized by you, required by law or in the case of an emergency. You may also request that your PHI is not disclosed to family members or friends that may be involved in your care. The Practice will consider all such request, but is not required to agree or act on them. You have the right to have confidential information sent to you at an alternative location or by a means other than the postal service. You have the right to obtain a copy of this notice.

CONCERNS AND COMPLAINTS

If you feel that your privacy rights have been violated at any time or you do not agree with how your PHI is being disclosed, you can contact our Privacy Officer at the address listed below. The Practice will not retaliate against you for filing a complaint. You can also contact the Secretary of Health and Human Services.

256 North Wellwood Avenue, Lindenhurst, New York 11757

TEL: 631.957.7300 FAX: 631.957.5308

The terms of this notice may change at any time. A copy of the revised notice will be posted in the office in easily accessible areas and will be provided to you upon your request. This notice was published on January 01, 2010

Lindenhurst Physical Therapy
Patient Acknowledgement of Receipt of Privacy
Practices Notice

This is to acknowledge that I have received and reviewed Lindenhurst Physical Therapy's Notice of Privacy Practices. If I have any questions, I can contact the Practice at (631) 957-7300.

PRINT NAME: _____

SIGNATURE: _____ **DATE:** _____

Lindenhurst Physical Therapy

Consent for Treatment

(This form must be signed)

PROPOSED INTERVENTION/TREATMENT

Therapeutic Exercise
Gait Training
Modalities
Pool Therapy
Patient Education

Bed/transfer mobility
Manual Therapy
CPM
Wound Care

POSSIBLE RISK OF HARM/COMPLICATIONS

Therapeutic exercise: sore muscles and joints
Transfers and Gait Training: fall, injury from falls.
Manual Therapy: sore joints and ligaments. Rarely, dislocation, fracture, paralysis or death.
Modalities: rash, burns, skin damage: rare, burning, periosteum.
Pool Therapy: skin irritations; rare-drowning
Wound Care: skin irritations, infection, spread of infection, increased wound size.

ALTERNATIVE TO TREATMENT

Chiropractic Care
Acupuncture
Massage Therapy
No treatment, resulting in possible decrease in function

GOAL OF TREATMENT

Improve mobility
Improve function
Improve independence
Decrease pain

I was made aware of my diagnosis and prognosis by the Physical Therapist.

Date : _____

Physical Therapist: Robert Pesci, D.P.T., P.T.

Patient Name: _____

Patient Signature: _____

CANCELLATION AND NO-SHOW POLICY

Due to the rising cost of providing healthcare, Lindenhurst Physical Therapy now requires 24 hours' notice in the event of a cancellation. It is the Patient's responsibility, when he or she calls in, to have an alternative time in mind that will ensure that they get in the full prescribed number of treatments that week in accordance with the treatment plan. In some cases, this may not work since some forms of treatment do not work well if given two sequential days.

There is a \$25.00 charge for first cancellation or No-show without proper notice. The rate will increase to \$50.00 for subsequent occurrences. The patient should understand that this charge will not be covered by insurance, but will have to be paid by them personally. We schedule each patient for one-on-one time with the therapist, so that when you cancel at the last minute three people are hurt: The patient himself/herself because they are not getting the treatment they need in order to reach their treatment goals, the therapist who now has a space in their schedule since the time was reserved for that patient personally, and another patient who could have been scheduled for that treatment time if proper notice had been given.

The staff may exercise discretion in certain true emergency circumstances on a first "no-show" or improper cancellation. If the patient who is normally punctual or has some unforeseen problem, they may choose to overlook it the FIRST time. If you are unable to adhere to the treatment schedule you may need to be discharged from therapy until you are able to commit to the treatment plan.

Insurance coverage is dependent on authorizations received and must be used within a specific time frame. Failure to use your authorized visits does not ensure that you will be extended coverage.

We are here to help you achieve your maximal potential. That requires a commitment from us and you. Adhering to the treatment plan is necessary to achieve your treatment goals.

Patient's **Print** Name

Patient's/ Guardian's **Signature**

Date

LINDENHURST PHYSICAL THERAPY

Terms and Conditions

Lindenhurst Physical Therapy will bill your insurance carrier at our contracted rates. If a co-payment is due, you will be responsible for meeting your payment after each visit. Please be aware of your insurance policy provisions. If our facility is denied payment for any reason due to these provisions, you will be responsible to pay us for the denied visits. If you have any questions about which limitations apply to you, please ask the billing department or contact your insurance directly. Once your insurance benefits are exhausted, if you wish to continue physical therapy, you will be responsible for our private fee. If we decide to go out of network with your insurance, the checks will be addressed and could be mailed to you and it will be your responsibility to sign them off and either mail or deliver them to us.

In the event that this account should be placed in the hands of an outside attorney for collection, the responsible party agrees to pay all outside costs of collection, including reasonable attorneys' fees not to exceed 20% of the unpaid balance together with court costs and disbursements.

If you are unable to keep your appointment, please give the office a 24 hour cancellation notice. If 24 hour cancellation is consistently not given, we will no longer schedule appointments in advance, and we will ask that you call for your appointment on the same day you would like to come in.

I have also advised Lindenhurst Physical Therapy that my condition being treated is directly related to work and/or an on the job injury, or is due to any motor vehicle accident. Please note, when you miss or cancel an appointment, your insurance carrier will be notified of the missed appointment.

I have read the above and I agree to these terms and conditions

Signature: _____

Print Name: _____

Date: _____

NOTICE THAT YOU MAY BE RESPONSIBLE FOR MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE, OR IF COMPENSATION CLAIM IS DISALLOWED, OR IF AGREEMENT PURSUANT TO WCL §32 IS APPROVED

WCB CASE NO. (If Known)		CARRIER CASE NO. (If Known)	DATE OF INJURY	NATURE OF INJURY OR ILLNESS	INJURED PERSON'S SOC. SEC. NO.
CLAIMANT		NAME		ADDRESS	APT. NO.
EMPLOYER					
INSURANCE CARRIER					

You may become responsible for the medical costs of treatment for your illness or condition with the provider listed below if (1) you fail to prosecute the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.

I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment.

Claimant's Signature _____ Date _____

Provider's Name and Address _____

TO THE CLAIMANT

Workers' Compensation Board Regulation 325-1.23 permits your doctor or therapist to request that you sign this A-9 notice. By signing this notice, you acknowledge your obligation to pay the provider's fees for the services you receive if it turns out that such fees are not legally required to be paid by your employer or its workers' compensation insurance carrier and if such fees are not covered by other insurance. The employer or carrier may not be required to pay the doctor's fees if, for example, you fail to file a claim for workers' compensation, or fail to notify your employer of your injury or illness, or fail to attend a Board hearing if your employer challenges your right to benefits. Even if you make all required efforts to prosecute your claim, the Workers' Compensation Board may still find that you are not entitled to benefits. In such cases, this notice advises your health provider that you acknowledge your personal liability for payment of his/her bills.

Workers' Compensation Law Section 32

The A-9 notice also covers instances in which a claimant with an existing valid workers' compensation case comes to an agreement with his/her employer or its insurance carrier settling his/her case in accordance with Section 32 of the Workers' Compensation Law. A Section 32 agreement may include a provision which relieves the employer or carrier of the liability to pay future medical bills associated with the case. Your health care provider may ask you to sign this A-9 notice to insure that you acknowledge your personal liability for payment of his/her bills if you have waived your right to future medical benefits under a Section 32 agreement.

If you have any questions, contact your attorney or licensed hearing representative, if you have one. You may also contact your local district office of the Workers' Compensation Board.

TO THE HEALTH CARE PROVIDER

This notice is meant to advise the workers' compensation claimant that he/she may be responsible for payment. Failure of the claimant to sign this form does not relieve the provider of the obligation to treat the claimant, nor does it negate the claimant's responsibility for payment.

Keep the original of this form for your records and give a copy to the claimant. **Do not file with the Workers' Compensation Board.** You will receive Notices of Decisions in which the compensability of a claim, authorization of treatment, or payment of medical bills is included. You will also be notified if the claimant submits a Section 32 Agreement with the Board for approval. Do not bill the claimant unless and until you receive a Board decision finding that 1) claimant failed to prosecute the claim, or 2) the claim is denied, or 3) the treatment is not causally related to the work injury, or 4) a Section 32 agreement relieving the carrier of liability for medical treatment is approved.

Lindenhurst Physical Therapy
Medical History

Are you under a physician's care now? YES NO If Yes, explain: _____

Have you ever been hospitalized or had a major operation? YES NO If Yes, explain: _____

Have you ever had a serious neck or head injury? YES NO If Yes, explain: _____

Are you taking any medications, pills or drugs? YES NO If Yes, explain: _____

Have you ever taken Fosamax, Boriva, Actonel or any other medications containing bisphosphonates? YES NO If Yes, explain: _____

Are you on a special diet? YES NO

Do you use tobacco? YES NO If Yes, how often: _____

Do you currently use recreational or street drugs? YES NO If Yes, explain: _____

Do you use controlled substances? YES NO

Women: are you Pregnant/Trying to get pregnant? YES NO

Taking oral contraceptives? YES NO

Nursing? YES NO

Have you had any injuries related to work? YES NO If Yes, date of accident: _____

Have you had any injuries related to an Auto Accident? YES NO If Yes, date of accident: _____

Have you had Physical Therapy before? YES NO If Yes, when: _____

Marital Status MARRIED SINGLE DIVORCED SEPERATED WIDOWED DOMESTIC PARTNER

How often do you exercise? NEVER OCCASSIONALLY MODERATELY HIGH LEVEL

How often do you drink alcohol? OCCASSIONALLY < 3X/WK > 3X/WK # DRINKS/WK: _____

Do you have, or have you had any of the following?

AIDS/ HIV Positive	<input type="checkbox"/> YES <input type="checkbox"/> NO	Cortisone Medicine	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hemophilia	<input type="checkbox"/> YES <input type="checkbox"/> NO	Radiation Treatments	<input type="checkbox"/> YES <input type="checkbox"/> NO
Alzheimers Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hepatitis A	<input type="checkbox"/> YES <input type="checkbox"/> NO	Recent Weight loss	<input type="checkbox"/> YES <input type="checkbox"/> NO
Anaphylaxis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Drug Addiction	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hepatitis B or C	<input type="checkbox"/> YES <input type="checkbox"/> NO	Renal Dialysis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Anemia	<input type="checkbox"/> YES <input type="checkbox"/> NO	Easily winded	<input type="checkbox"/> YES <input type="checkbox"/> NO	Herpes	<input type="checkbox"/> YES <input type="checkbox"/> NO	Rheumatic Fever	<input type="checkbox"/> YES <input type="checkbox"/> NO
Angina	<input type="checkbox"/> YES <input type="checkbox"/> NO	Emphysema	<input type="checkbox"/> YES <input type="checkbox"/> NO	High Blood Pressure	<input type="checkbox"/> YES <input type="checkbox"/> NO	Rheumatism	<input type="checkbox"/> YES <input type="checkbox"/> NO
Arthritis/ Gout	<input type="checkbox"/> YES <input type="checkbox"/> NO	Epilepsy or Seizures	<input type="checkbox"/> YES <input type="checkbox"/> NO	High Cholesterol	<input type="checkbox"/> YES <input type="checkbox"/> NO	Scarlet Fever	<input type="checkbox"/> YES <input type="checkbox"/> NO
Artificial Heart Valve	<input type="checkbox"/> YES <input type="checkbox"/> NO	Excessive Bleeding	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hives or Rash	<input type="checkbox"/> YES <input type="checkbox"/> NO	Shingles	<input type="checkbox"/> YES <input type="checkbox"/> NO
Artificial Joint	<input type="checkbox"/> YES <input type="checkbox"/> NO	Excessive Thirst	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hypoglycemia	<input type="checkbox"/> YES <input type="checkbox"/> NO	Sickle Cell Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO
Asthma	<input type="checkbox"/> YES <input type="checkbox"/> NO	Fainting Spells/Dizziness	<input type="checkbox"/> YES <input type="checkbox"/> NO	Irregular Heartbeat	<input type="checkbox"/> YES <input type="checkbox"/> NO	Sinus Trouble	<input type="checkbox"/> YES <input type="checkbox"/> NO
Blood Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Frequent Cough	<input type="checkbox"/> YES <input type="checkbox"/> NO	Kidney Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO	Spina Bifida	<input type="checkbox"/> YES <input type="checkbox"/> NO
Blood Transfusion	<input type="checkbox"/> YES <input type="checkbox"/> NO	Frequent Diarrhea	<input type="checkbox"/> YES <input type="checkbox"/> NO	Leukemia	<input type="checkbox"/> YES <input type="checkbox"/> NO	Stomach/Intestinal Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO
Breathing Problem	<input type="checkbox"/> YES <input type="checkbox"/> NO	Frequent Headaches	<input type="checkbox"/> YES <input type="checkbox"/> NO	Liver Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Stroke	<input type="checkbox"/> YES <input type="checkbox"/> NO
Bruise Easily	<input type="checkbox"/> YES <input type="checkbox"/> NO	Genital Herpes	<input type="checkbox"/> YES <input type="checkbox"/> NO	Low Blood Pressure	<input type="checkbox"/> YES <input type="checkbox"/> NO	Swelling of Limbs	<input type="checkbox"/> YES <input type="checkbox"/> NO
Cancer	<input type="checkbox"/> YES <input type="checkbox"/> NO	Glaucoma	<input type="checkbox"/> YES <input type="checkbox"/> NO	Lung Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Thyroid Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO
Chemotherapy	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hay Fever	<input type="checkbox"/> YES <input type="checkbox"/> NO	Mitral Valve Prolapse	<input type="checkbox"/> YES <input type="checkbox"/> NO	Tonsilitis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Chest Pains	<input type="checkbox"/> YES <input type="checkbox"/> NO	Heart Attack/Failure	<input type="checkbox"/> YES <input type="checkbox"/> NO	Osteoporosis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Tuberculosis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Cold Sores/ Fever Blisters	<input type="checkbox"/> YES <input type="checkbox"/> NO	Heart Murmur	<input type="checkbox"/> YES <input type="checkbox"/> NO	Pain in Jaw Joints	<input type="checkbox"/> YES <input type="checkbox"/> NO	Tumors or Growths	<input type="checkbox"/> YES <input type="checkbox"/> NO
Congenital Heart Disorder	<input type="checkbox"/> YES <input type="checkbox"/> NO	Heart Pacemaker	<input type="checkbox"/> YES <input type="checkbox"/> NO	Parathyroid Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Ulcers	<input type="checkbox"/> YES <input type="checkbox"/> NO
Convulsions	<input type="checkbox"/> YES <input type="checkbox"/> NO	Heart Trouble/Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Psychiatric Care	<input type="checkbox"/> YES <input type="checkbox"/> NO	Venereal Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO

Have you ever had any serious illness not listed above? YES NO If Yes, explain: _____

Signature: _____

Date: _____

Lindenhurst Physical Therapy

Health History Questionnaire

Your answers on this form will help Lindenhurst Physical Therapy better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. All questions contained in this questionnaire are optional and will be kept strictly confidential.

ALLERGIES

List anything that you are allergic to (medications, food, etc.) and how each affects you.

Allergy	Reaction
1.	
2.	
3.	

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, i.e. vitamins and inhalers.












Drug Name	Strength	Frequency Taken
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Name: _____

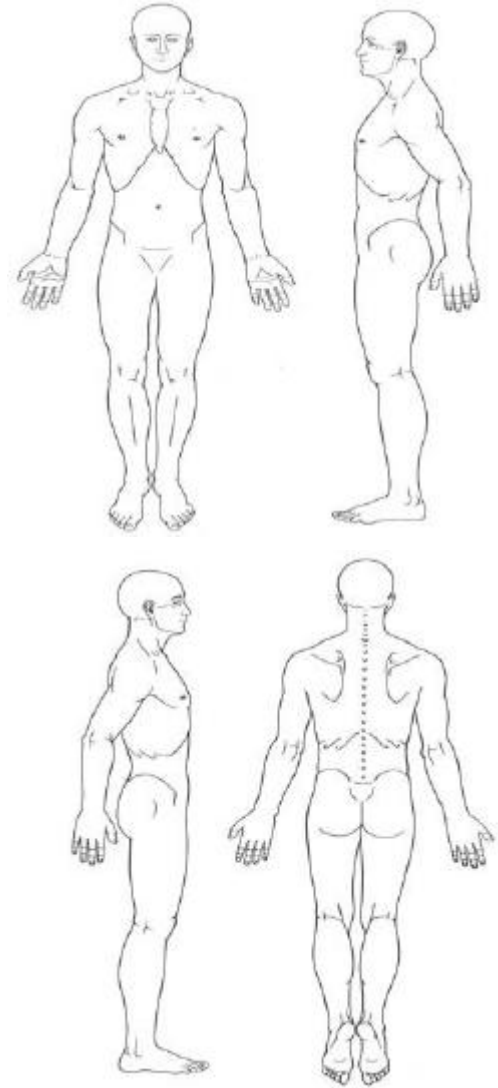
Date: _____

LINDENHURST PHYSICAL THERAPY

PAIN ASSESSMENT

	10	WORST PAIN POSSIBLE, UNBEARABLE. Unable to do any activities due to pain.
	9	
	8	INTENSE, DREADFUL, HORRIBLE. Unable to do most activities because of pain.
	7	
	6	MISERABLE, DISTRESSING. Unable to do some activities due to pain.
	5	
	4	NAGGING PAIN, UNCOMFORTABLE, TROUBLESOME. Can do most activities with rest periods.
	3	
	2	MILD PAIN, ANNOYING. Pain is present, but does not limit activity
	1	
	0	NO PAIN.

Indicate where you have pain or other symptoms



PAIN ASSESSMENT LEVEL : PRESENT: ____/10, AT BEST: ____/10, AT WORST : ____/10

1. Describe your symptoms: _____

a. Onset of injury: _____

b. Mechanism of injury : _____

2. How often do you experience your symptoms?

- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)

3. What describes the nature of your symptoms?

- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- ⑥ Tingling

Signature: _____ **Date:** ____/____/____