



**OM PHYSICAL THERAPY**  
**OM PHYSICAL THERAPY - NEW PATIENT INTAKE FORM**  
**(Personal Injury/Private Insurance)**

**Welcome to OM Physical Therapy!** We are here to support your journey to recovery and improve health. Please fill out this form to help us tailor our care to your specific needs.

<b>PATIENT INFORMATION</b>			
Patient's full name (last, first, middle)			
Home Address		City	State Zip
Birth sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN		Dob (mm/dd/yyyy)
Home phone <input type="checkbox"/> Ok to call <input type="checkbox"/> Ok to text	Cell phone <input type="checkbox"/> Ok to call <input type="checkbox"/> Ok to text		Work phone <input type="checkbox"/> Ok to call <input type="checkbox"/> Ok to text
Email		How did you hear about us?	
Primary Care physician	Address		Phone
Referring physician (if different from primary care)	Address		Phone
Emergency contact name		Relation	Phone
Employment Status: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Not Working			
<b>INJURY/ILLNESS INFORMATION</b>			
Note: Please present a copy of your physical therapy prescription from your physician, if you have it, to the front desk during your initial visit.			
Diagnosis of your injury (if known):	Date of injury/illness (mm/dd/yyyy)	Date of surgery (mm/dd/yyyy)	
Current Injury/condition as a result of <input type="checkbox"/> Personal Injury <input type="checkbox"/> Motor Vehicle Accident/No-Fault <input type="checkbox"/> On the Job/Workers' Compensation			



## OM PHYSICAL THERAPY

### PRIMARY INSURANCE INFORMATION

**Note:** Provide Commercial/Private/Public insurance information (Ex: Blue Cross/Metroplus/Medicare/Medicaid).  
**Note:** Please present a copy of all your insurance cards to the front desk during your initial visit.

Primary insurance company		Phone number	
Insurance address			
Subscribers name		Subscribers dob (mm/dd/yyyy)	Relation
Id#		Group id#	
Employer Name			
Employer address		Phone	

### SECONDARY INSURANCE INFORMATION

Secondary insurance company		Phone number	
Insurance address			
Subscribers name		Subscribers dob (mm/dd/yyyy)	Relation
Id#	Group id#	Employer / phone	

### GUARANTOR INFORMATION

Guarantor name		Phone	Dob	
Address		City	State	Zip

**Certification:** By signing below, I affirm that the information provided here is accurate to the best of my knowledge.

**Signature:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

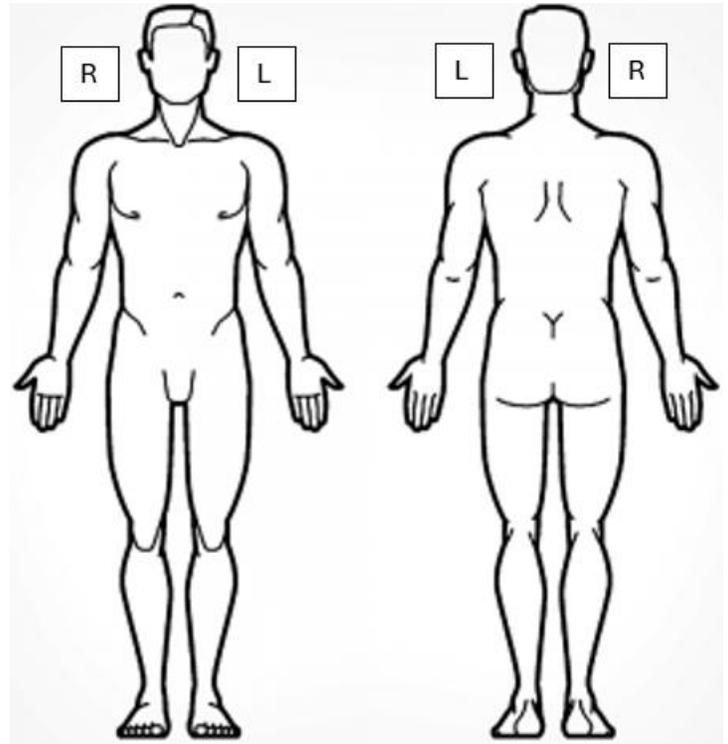
OM PHYSICAL THERAPY - COMPREHENSIVE MEDICAL HISTORY FORM

Current Condition/Major Complaints:

• What are you/the patient being seen for?

(Please circle where you feel pain/discomfort)

- Neck
- Shoulder
- Elbow or Upper Arm
- Forearm or Hand
- Wrist
- Mid Back
- Lower Back
- Hip
- Thigh
- Knee    Lower Leg    Ankle or Foot



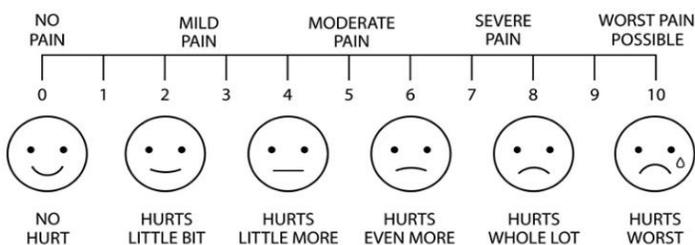
• Date of condition onset/ When did your pain start: \_\_\_\_\_

• Is your current condition/complaint a result of,

- Personal Injury    Motor Vehicle Accident/No-Fault    On the Job/Workers' Compensation

• Describe pain (please circle): Sharp Dull Aching Throbbing Cramping Burning Shooting Stabbing Constant Intermittent

• Pain Assessment: Rate your pain on a scale of 0 to 10 (0 = No pain, and 10 = Unbearable pain)



Pain at its best: \_\_\_\_\_

Pain today: \_\_\_\_\_

Pain at its worst: \_\_\_\_\_

What makes it worse? \_\_\_\_\_

What makes it better? \_\_\_\_\_

Does time of day affect pain?  Yes  No

Does pain wake you from sleep?  Yes  No

Daily activities affected by pain \_\_\_\_\_ %



- Do you have tingling, numbness, or loss of sensation?  Yes  No If so, where? \_\_\_\_\_
- Do you have weaknesses?  Yes  No If so, where and for how long? \_\_\_\_\_
- Do you have swelling?  Yes  No If so, where? \_\_\_\_\_

**Lifestyle Information**

- Do you use tobacco?  Yes  No If yes, \_\_\_ # of packs per day
- Do you consume alcohol?  Yes  No If yes, \_\_\_ # of drinks per day
- Do you wear glasses or contacts?  Yes  No
- Do you wear dentures or use a hearing aid?  Yes  No
- Do you have a pacemaker?  Yes  No
- Do you have any metal implants?  Yes  No
- Do you use a cane or crutches?  Yes  No
- Do you use a walker or wheelchair?  Yes  No
- Have you fallen two or more times?  Yes  No
- Have you sustained an injury as a result of these falls?  Yes  No
- For female patients only: Are you pregnant?  Yes  No If yes, \_\_\_ # of weeks pregnant

**Current Medications:** Please list all medications including prescriptions, OTCs, herbals, and any supplements.

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_ Administration Route: \_\_\_\_\_  
 Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_ Administration Route: \_\_\_\_\_  
 Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_ Administration Route: \_\_\_\_\_  
 Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_ Administration Route: \_\_\_\_\_

No current medication

**Surgical History** List any surgeries you have had including the type and date.

**Surgery Type:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Surgery Type:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Surgery Type:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Diagnostic and Treatment History** Have you received any of the following for this condition?

- Chiropractic Care
- CT Scan
- General Practitioner
- MRI
- EMG/NCV Tests
- Myelogram
- Massage Therapy
- Neurological Consult
- Occupational Therapy
- Orthopedic Care
- Physical Therapy
- Podiatry Services
- Emergency Room Services
- X-rays



**Past Medical History** Check any conditions you currently have or have had in the past.

High Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N	Parkinson's Disease	<input type="checkbox"/> Y <input type="checkbox"/> N
High Cholesterol	<input type="checkbox"/> Y <input type="checkbox"/> N	COPD/Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N
Bowel/Bladder Dysfunction	<input type="checkbox"/> Y <input type="checkbox"/> N	Emphysema	<input type="checkbox"/> Y <input type="checkbox"/> N
Acid Reflux/Ulcers	<input type="checkbox"/> Y <input type="checkbox"/> N	Lupus	<input type="checkbox"/> Y <input type="checkbox"/> N
Thyroid Disorder	<input type="checkbox"/> Y <input type="checkbox"/> N	Kidney Disease	<input type="checkbox"/> Y <input type="checkbox"/> N
Bleeding Disorder	<input type="checkbox"/> Y <input type="checkbox"/> N	Stroke	<input type="checkbox"/> Y <input type="checkbox"/> N
HIV/AIDS	<input type="checkbox"/> Y <input type="checkbox"/> N	Osteoarthritis	<input type="checkbox"/> Y <input type="checkbox"/> N
Seizures/Epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N	Rheumatoid Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N
Lyme Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Osteoporosis/Osteopenia	<input type="checkbox"/> Y <input type="checkbox"/> N
Congestive Heart Failure	<input type="checkbox"/> Y <input type="checkbox"/> N	Scoliosis	<input type="checkbox"/> Y <input type="checkbox"/> N
Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	Headaches/Migraines	<input type="checkbox"/> Y <input type="checkbox"/> N
Heart Attack	<input type="checkbox"/> Y <input type="checkbox"/> N	Dizziness/Fainting	<input type="checkbox"/> Y <input type="checkbox"/> N
Cardiac Bypass	<input type="checkbox"/> Y <input type="checkbox"/> N	Dementia/Alzheimer's	<input type="checkbox"/> Y <input type="checkbox"/> N
Cardiac Stent	<input type="checkbox"/> Y <input type="checkbox"/> N	Recent Infection	<input type="checkbox"/> Y <input type="checkbox"/> N
Chest Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Multiple Sclerosis	<input type="checkbox"/> Y <input type="checkbox"/> N
Hepatitis	<input type="checkbox"/> Y <input type="checkbox"/> N	Fibromyalgia	<input type="checkbox"/> Y <input type="checkbox"/> N
Mental Disorder	<input type="checkbox"/> Y <input type="checkbox"/> N	Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N
If yes, what type: _____		If yes, what type: _____	
Allergies	<input type="checkbox"/> Y <input type="checkbox"/> N	Please list allergies: _____	
Other not listed: _____			

**Certification:** By signing below, I affirm that the information provided here is accurate to the best of my knowledge.

**Signature:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_



## OM PHYSICAL THERAPY - OFFICE POLICY FOR PATIENT CARE AND INSURANCE HANDLING

**Commitment to Excellence:** At OM Physical Therapy, our dedication is to provide you with the highest quality of care possible. We strive to assist you in maximizing your insurance benefits. For us to support you effectively, we appreciate your cooperation and understanding of our financial policies.

**Payment Information:** All service fees are expected at the time of service unless prior arrangements have been made with our office. We accept various forms of payment, and details about acceptable payment methods are available upon request. As a service to our patients, we verify insurance coverage and communicate with your insurance providers to facilitate claims.

**Insurance Assignment:** If we participate with your insurance provider, we will process your claims directly. Payments from your insurance will be directed to our office. You are responsible for any applicable deductibles, co-payments, and coinsurance, which are due at the start of each visit. We are available to discuss your treatment plan and any insurance-related inquiries at any time.

**Understanding Your Insurance:** It is important to remember that your insurance policy is a contract between you and your insurance company, and we are not a party to that contract. Our fees generally fall within the range accepted by most insurance carriers, and therefore, should be covered up to the maximum allowed by your plan. This applies to carriers that reimburse a percentage of the usual, customary, and reasonable (UCR) rates. However, this may not apply to plans that use a different fee schedule, which may not reflect the current standards and costs of care in this region.

**Coverage Details:** Not all services may be covered under your insurance contract, and some plans may exclude certain services. Because our primary relationship is with you and not with your insurer, we recommend that you verify the specifics of your coverage. Providing inaccurate insurance information remains your responsibility. While we facilitate insurance claims as a courtesy, all service charges are your responsibility from the time they are incurred. We understand that financial issues can arise and affect timely payment; we encourage you to contact us immediately for support in managing your account.

**Questions and Support:** If you have any concerns or questions about this policy or your insurance coverage, please do not hesitate to speak with us. We are here to assist you.

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**Patient/Guardian Signature of Acknowledgement**

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**Date**



## OM PHYSICAL THERAPY- INFORMED CONSENT FOR THERAPY SERVICES

**Overview of Therapy Services:** At OM Physical Therapy, we employ a range of physical evaluation techniques and therapeutic interventions aimed at enhancing your functional abilities. Like all medical treatments, these interventions come with both potential benefits and inherent risks.

**Individual Responses to Treatment:** The effectiveness of a specific treatment can vary greatly among individuals, making it challenging to precisely predict how you will respond to a therapy modality or procedure. We cannot guarantee specific results or assure that the therapy will fully address the condition for which you are being treated. Additionally, there is a possibility that treatment could cause discomfort or exacerbate pre-existing conditions.

**Patient Rights and Communication:** You are encouraged to inquire about the nature of your treatment plan, which is designed based on your medical history, current diagnosis, symptoms, and any test results. You have the opportunity to discuss potential risks and benefits with your therapist. It is your right to refuse or discontinue any part of your treatment at any point.

**Risks Associated with Therapeutic Exercises:** Therapeutic exercises, which will be a core component of your treatment, carry their own set of risks. Should you have any concerns or need clarification about the exercises you are undertaking, our therapists are available to provide comprehensive answers and support.

**Consent to Proceed:** By signing this document, I confirm that the details of the therapy program have been thoroughly explained to me, all my questions have been addressed, and I understand the risks involved with undergoing Physical, Occupational, or Speech Therapy. I agree to proceed with the treatment plan as recommended by my healthcare provider.

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**Patient/Guardian Signature of Acknowledgement**

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**Date**



## OM PHYSICAL THERAPY- NOTICE OF PRIVACY PRACTICES AND CONSENT (HIPAA)

**Understanding Your Rights:** Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, you have specific rights concerning the privacy of your protected health information. This information will be used in the following ways:

- **For Treatment:** To coordinate, manage, and administer your medical treatment and services among healthcare providers involved in your care.
- **For Payment:** To secure payment for health care services provided, from insurers and other third-party payers.
- **For Healthcare Operations:** To support essential healthcare operations such as quality reviews and physician evaluations.

**Comprehensive Privacy Notice:** I acknowledge that I have read and understood the detailed notice of privacy practices, which provides more extensive information on how my health information may be used and disclosed. I am aware that the organization may modify its privacy practices and that I can obtain the most recent version of this notice upon request.

**Restriction Requests:** I understand that I have the right to request restrictions on how my health information is used or disclosed for treatment purposes, although the organization is not obligated to comply with such requests.

**Consent Revocation:** I reserve the right to withdraw my consent at any time in writing, except to the extent that actions have already been taken based on this consent.



Instructions for the Use  
of the HIPAA-compliant Authorization Form to  
Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act (“HIPAA”) and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as “at the conclusion of my court case” or provide a specific date amount of time, such as “3 years from this date”.

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.



## OM PHYSICAL THERAPY- ASSIGNMENT & RELEASE OF BENEFITS

I \_\_\_\_\_ (patient name) hereby designate OM Physical Therapy as my authorized representative and assign them my rights to file for, receive, and collect payments due for services rendered to me from any third-party payer, including but not limited to my health insurance provider, Medicare, Medicaid, or other governmental programs ("my Plan"), applicable during the period I am eligible for such payments. I grant permission for OM Physical Therapy to exchange treatment documentation and discuss my treatment details with my Plan.

Furthermore, I authorize OM Physical Therapy to undertake any necessary actions to assert and pursue my legal rights to claim payments under my Plan. This includes pursuing appeals, grievances, litigation, or arbitration as needed. Should my Plan issue payments directly to me, I commit to forwarding those payments to OM Physical Therapy within ten (10) days of receipt.

\_\_\_\_\_  
**Patient/Guardian Signature of Acknowledgement**

\_\_\_\_\_  
**Date**



## OM PHYSICAL THERAPY- NOTICE OF ADVICE TO MEDICARE PATIENTS

### THE ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE (ABN)

**Medicare Coverage and Limits:** OM Physical Therapy is an authorized provider for Medicare services. The Medicare reimbursement cap for combined outpatient Physical and Speech Therapy services is set at \$2,410 (\$2,410 is set for the year 2025, subject to change annually by CMS), and the same cap applies to outpatient Occupational Therapy services.

**Reimbursement Details:** Medicare covers 80% of the costs for therapy services; the remaining 20% is the responsibility of the patient. For patients with secondary insurance, OM Physical Therapy will process claims with your secondary insurer as a courtesy.

**Physician Follow-Up Requirements:** Medicare stipulates that patients must consult with their referring physician every 30 days. It is your obligation to secure a new prescription from your physician during each follow-up.

**Home Health Care Coordination:** Please inform us immediately if you are receiving any Home Health Services. Medicare does not cover outpatient physical therapy services if you are concurrently receiving Home Health services or have not been formally discharged from such services.

- **Have you received any Home Health services this year?** Yes \_\_\_ No \_\_\_
  - **If yes, name of the provider/s:** \_\_\_\_\_
  - **Provider phone#** \_\_\_\_\_
  - **Did you take a discharge?** Yes \_\_\_ No \_\_\_
  
- **Have you undergone any outpatient physical therapy this year?** Yes \_\_\_ No \_\_\_
- **If you have undergone any outpatient physical therapy this year, please specify,**
  - **Name of the provider/s:** \_\_\_\_\_
  - **Provider phone#** \_\_\_\_\_
  - **Number of visits taken this year:** \_\_\_\_\_
  - **Did you take a discharge?** Yes \_\_\_ No \_\_\_

**Patient Financial Responsibility:** All deductibles, copays, and coinsurance amounts are due by the patient. Upon receipt of payment details from your insurance provider, we will issue a statement outlining your financial responsibilities.

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**Patient's Name**

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**Patient/Guardian Signature of Acknowledgement**

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**Date**



**OM PHYSICAL THERAPY- NOTICE OF ADVICE TO THE PATIENT WITHOUT REFERRAL**

**DIRECT ACCESS LAW COMPLIANCE**

**New York State Direct Access Law Overview**

Under Chapter 298 of the Laws of 2006, qualified physical therapists in New York State—with at least three years of practical experience—may provide treatment without a physician’s, dentist’s, podiatrist’s, or nurse practitioner’s referral as per the Direct Access Law. This law excludes treatment for patients covered under workers' compensation, no-fault insurance, Medicare, or involved in pending liability cases.

**Patient Acknowledgment and Agreement:**

- **Coverage and Referral:** I acknowledge that my treatment may not be reimbursed by my healthcare plan or insurer without a proper referral and that securing a referral could potentially allow for coverage.
- **Insurance Verification:** It is my responsibility to confirm with my insurance provider whether treatments are covered under Direct Access, without a referral.
- **Limitation on Services:** Treatment under Direct Access is restricted to ten (10) visits or thirty (30) days from the commencement date, whichever comes first.
- **Physical Therapy will start on** \_\_\_\_\_ **(Date)**
- **Exclusion Declaration:** I confirm that my treatment is not associated with any no-fault or workers' compensation claim, there is no pending liability case concerning my condition, and I am not a Medicare beneficiary.
- **Financial Responsibility:** I understand and accept that I am fully responsible for payments for the treatment sessions that are not covered by my health insurance under Direct Access.

**Consent to Treatment:** I have read and comprehended this notice regarding the Direct Access Law in New York State. I consent to undergo physical therapy treatment at OM Physical Therapy without a referral from a physician, dentist, podiatrist, or nurse practitioner.

**Patient Name:** \_\_\_\_\_

**Patient Address:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Name of Treating Therapist:** \_\_\_\_\_

**Address of Treating Therapist:** \_\_\_\_\_

**Signature of Treating Therapist:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**If Applicable, Legal Guardian Information:**

**Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



## OM PHYSICAL THERAPY CODE OF CONDUCT FOR PATIENTS, FAMILIES, AND VISITORS

**Commitment to Safety and Respect** At OM Physical Therapy, we are committed to creating and sustaining a secure and respectful environment for all our patients, their families, and visitors. This Code of Conduct is established to guide behavior and interactions within our facilities and is applicable to everyone.

### **Expected Behavior:**

- **Respectful Interaction:** All individuals in the clinic, including staff, patients, and visitors, are expected to treat each other with respect at all times.
- **Prohibited Items:** Weapons, illegal substances, alcohol, cannabis, tobacco, and any hazardous items are strictly forbidden within clinic premises.

### **Unacceptable Behaviors Include:**

- **Discriminatory Language or Actions:** No form of discriminatory, racist, hostile, or harassing behavior or language will be tolerated. This includes, but is not limited to:
  - Derogatory comments related to race, ethnicity, religion, gender identity, sexual orientation, or any other personal characteristic.
  - Avoiding or refusing to interact with staff members based on personal characteristics.
  - Threatening or assaulting behavior, either verbal or physical.
  - Inappropriate sexual or vulgar comments or gestures.
  - Disruptions to the care or experience of others, such as shouting or swearing.
  - Unauthorized photography or recording of individuals within the facility.

**Consequences of Misconduct:** Individuals who fail to adhere to this code will be required to leave the premises and may need to seek services elsewhere for future care needs. Repeated violations may result in further restrictions.

**Reporting Concerns:** Should you encounter or observe any behavior that violates this code, please inform a member of your care team immediately. We are here to ensure a safe and welcoming environment for everyone.