PATIENT CONSENT FORM

TEL: (631) 596-5096

FAX: (631) 594-5370

www.greinerpt.com

"Get Better Faster from the Comfort of Home"

Serving Eastern Long Island

Thank you for choosing Seth Greiner PT, PLLC. We are committed to providing you with the best possible medical care. Please carefully read the following, and sign below.

We will do our best to verify that we can treat you. This is however, no guaranty of benefit. It is your responsibility to know your insurance policy and initiate an referral when necessary. Any questions regarding your policy deductibles and co-pay should be referred to your insurance company.

INSURANCE: Your insurance is a contract between you and your insurance company, and we are not a party to that contract. For those patients whose plan accept Seth Greiner PT, PLLC as a contract provider, we will submit the appropriate claim to your carrier. After our office has received payment from your insurance company and all appropriate adjustments have been made, your remaining balance will be billed to you and is then due and payable upon receipt of the bill. In the event your insurance company requests a refund or a denial of payments, you will be responsible for the amount of money refunded or due for services provided. Be advised our services may be OUT OF NETWORK for your policy, which could result in you having to meet an additional deductible.

PAYMENT FOR SERVICES: Payment is due at the time services are rendered or upon receipt of the patient billing statement. In order to expedite this payment Seth Greiner PT, PLLC accepts cash or personal checks. I agree to pay for services at the time they are rendered.

ASSIGNMENT OF BENEFITS: I hereby authorize Seth Greiner PT, PLLC to bill my insurance company and for my insurance company to remit payments to Seth Greiner PT, PLLC for services rendered.

PROTECTION OF PATIENT INFORMATION: Your personal health information is held in confidence and no information will be given out without your direct consent. By signing this form I acknowledge the notice of privacy practices and give permission to use information solely for the purpose of collection of claims. If information is requested by anyone or company other than your insurance or yourself, you will need to provide us with a release of information form in writing.

CONSENT TO EVALUATION AND TREATMENT: I do hereby consent to the evaluation and treatment by Seth Greiner, PT PLLC. I understand it is my right to accept or refuse any treatment offered me. I acknowledge and understand that no guarantee has been made to me as the results that may be obtained from such treatment.

ATTENDANCE POLICY: The plan the therapist recommends for you is essential to follow for your care to be successful. I agree to give at least 24 hour notice for any rescheduling of appointments. I agree that Seth Greiner PT, PLLC reserves the right to discharge me from their care with 3 or more unexcused cancellations in any 4 week period of my care.

CANCELLATION POLICY: If you wish to change or cancel an appointment we require a minimum ***24-hour advance notice***. Anything less will result in a ***$25 fee*** charged to your account. It costs us money to make appointments available to you. We don't charge you the actual cost for that appointment but rather a mere ***$25 fee***. We do NOT make money with this charge; it's only to act as a deterrent from making last minute changes. Advance notice allows someone else (who needs it) time to reserve it in place of you. Please be courteous and responsible.

If you enroll or are currently enrolled with a Home Health Care agency, our physical therapy services will NOT be covered until you are discharged from that Home Health Care agency. If this happens you will be responsible for the cost of the physical therapy services(up to $125.00 per visit). To receive services through Medicare, please acknowledge/check the following boxes.

- ☐ I am not seeing a nurse in my home
- ☐ I am receiving wound care
- ☐ I am not seeing a social worker in my house
- ☐ I am not receiving physical, occupational, or speech

I have read and understood the above information. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

Patient Name _____

Patient Signature _____ Date _____

PATIENT MEDICATION LIST

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BELOW IS LISTED MY CURRENT MEDICATIONS. IF ANY OF MY MEDICATIONS CHANGE I WILL INFORM MY THERAPIST.

PATIENT NAME:			**DATE:**	
Medication Name	**Dosage**	**Frequency**	**Method Of Intake**	**Reason For Usage**
PATIENT SIGNATURE:				
DATE:				

Pre-Exam Form

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Patient Name _____ Age _____

Occupation _____

1. Where/What is your pain/problem? _____
2. What caused your pain/problem? _____
3. Approximately when did it start? _____
4. Have you ever had this pain/problem before? _____
5. In your understanding, what do you think will make it better? _____
6. How optimistic are you that you'll get better? (circle one)

   Not at All Mildly Optimistic Fairly Very Optimistic Extremely

7. Over the next month how many hours per week will you commit to getting better? _____
8. What are some potential obstacles to you getting better? _____
9. What are you expecting from your physical therapy program? _____
10. On the scale below circle your worst pain level in the past couple of days

    (none at all) 0.….1…..2…..3…..4…..5…..6…..7…..8…..9…..10 (highest)

11. Are any of your everyday activities are affected by this problem? O Yes O No

    If Yes, list how. _____

12. List all past surgeries with dates _____
13. List all relevant medical conditions _____

I understand that my candidacy for a rehabilitation program will be dependent upon my ability and willingness to improve. I have answered the questions above honestly and accurately to the best of my ability. The doctor/therapist will determine whether or not I am a viable candidate for a rehabilitation program and that my activation into their system is not guaranteed.

Patient Signature _____ Date _____