ECLIPSE
PHYSICAL THERAPY
AND WELLNESS

Patient Information:

Today's Date: ____/____/_____
First Name: _____
Last Name: _____
Birth date: ____/____/_____
Social Security #: _____-_____-_____
Email: _____

Date of Injury/Surgery: ____/____/_____
Home Phone: _____
Cell Phone: _____
Mailing Address: _____
City: _____ State: ___ Zip code: _____
Marital Status: Single / Married / Other: _____

Emergency Contact Information:

First Name: _____
Last Name: _____
Mailing Address: _____
City: _____ State: ____ Zip code: _____

Relationship: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____

Employment Status:

Employed / Unemployed / Student / Retired
Other: _____
Occupation: _____
Employer Name _____

Address: _____
City: _____ State:____ Zip:_____
Phone: _____

Physician/Referring Information:

Primary Care Physician: _____
Primary Phone #: _____
Referring Physician: _____
Referring Phone #: _____

How did you hear about us? (please circle one)
Physician Driving by Insurance Co.
Internet Family Friend Other: _____

Insurance Information:

No Fault & Worker's Compensation Insurance
Is this a No Fault or Worker's Comp Case? Y/N
NF/WC Insurance: _____
Case/Claim #: _____

Address: _____
City: _____State: ____ Zip code: _____
Case Worker: _____
Phone #: _____

Primary Insurance: _____
Insured's Name: _____
Insured's Date of Birth: _____/_____/_____

Insured's Social Security #: _____/____/_____
Insurance ID #: _____

Secondary Insurance: _____
Insured's Name: _____
Insured's Date of Birth: _____/_____/_____

Insured's Social Security #: _____/____/_____
Insurance ID #: _____

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Name: _____ **Date: _____/_____/_____**

Medical History

Please check the appropriate box if you currently have, or have ever had, any of the following:

- ☐ Breathing problems
- ☐ Cancer
- ☐ Dental problems
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Blood vessel disease
- ☐ Stroke
- ☐ Heart attack
- ☐ Pacemaker
- ☐ Headaches
- ☐ Hearing aid
- ☐ Joint replacements
- ☐ Metal implants/fragments
- ☐ Arthritis
- ☐ Nervous system disorder
- ☐ Visual impairment
- ☐ Known allergies
- ☐ Previous surgeries
- ☐ Seizures
- ☐ Dizziness
- ☐ Currently pregnant
- ☐ Alcohol/drugs
- ☐ Infectious disease
- ☐ Smoker
- ☐ Fractures
- ☐ Skin condition
- ☐ Open wounds
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

If you have checked any of the above, please explain and give dates:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

List all current medications and the conditions they are taken for:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

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 Eclipse Physical Therapy and Wellness directly for services rendered.

If you must bring someone with you to therapy, we request that they please remain in the waiting room.

Patient's Signature_____ Date:_____
(Legal guardian if patient is under 18 years of age)

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Notice of Privacy Practices:

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____, hereby authorize Eclipse Physical Therapy and Wellness to disclose my protected health information to these individuals (family, friends, etc…) listed below, in addition to my physician.

	Name of Person	Relationship to Patient
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

This authorization shall be in effect until formally revoked. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Dan Millrood at Eclipse Physical Therapy and Wellness, P.O. Box 685 Kerhonkson, NY 12446 or via email to Dan@EclipsePT.com. I understand that revocation is not effective to the extent that Eclipse Physical Therapy has relied on the use or disclosure of the protected health information.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to inspect or copy the health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights) and/or refuse to sign this authorization. Eclipse Physical Therapy and Wellness will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

_____

Printed name of Patient (or legal guardian) Date

_____

Signature of Patient (or legal guardian)

_____

Description of Legal Guardian's Authority

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HEALTH SERVICES RELEASE

I certify that I am NOT currently having any home health services at this time, including nursing, etc…

I understand that if I am having home health services at the same time as outpatient physical therapy, my therapy may not be covered by my insurance and I will be responsible for all charges.

_____ ____/____/_____
Printed name of Patient (or legal guardian) Date

_____
Signature of Patient (or legal guardian)

FINANCIAL POLICY

We are committed to providing you with the best possible care and Eclipse Physical Therapy and Wellness is pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask the secretarial staff if you have any questions about our fees, financial policy, or your responsibility.

Payment is due for services at the time services are rendered. All co-insurance, co-payments, and deductibles are due as services are rendered. We submit all billing to insurance companies as a courtesy to our patients; however, we will collect the 20% deductibles and co-payment at the time of 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 (unless other financial arrangements have been made), the account will be turned over to a collection agency. Collection agencies charge 33% of the unpaid bill. Should these additional costs be incurred, you will be responsible for them in addition to any unpaid balance.

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

_____ ____/____/_____
Signature of Patient (or legal guardian) Date

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Attendance Policy/Consent for treatment:

I understand that my doctor has prescribed therapy for me and that physical therapy is an ongoing process which requires regular attendance to be optimally effective. Consequently, I am aware that not attending scheduled sessions may be jeopardizing my progress and also may adversely affect my disability status.

APPOINTMENTS:
Please be on time for your appointments so that you may be given the full benefit of your scheduled treatment. Late arrival of greater time than 15 minutes may result in a shortened treatment or cancellation. We require advance notice of 24 hours for cancellation.

RESPONSIBILITY:
It is your responsibility to contact your insurance company to verify your coverage for outpatient physical therapy. You need to verify your percentage of payment per visit, any co-payments, deductibles and limits of visits per calendar year. We at Eclipse Physical Therapy and Wellness will be glad to bill your insurance as a courtesy to you. But it is your responsibility for any portion not paid by insurance. If you need any assistance in this matter, please feel free to contact our business office or see the receptionist.

PATIENT ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I have read and understand the above stipulations and agree to comply with the appointment policy. Additionally, I have had access to Eclipse Physical Therapy and Wellness' policy regarding Notice of Privacy Practices. Should I have any questions regarding this notice, I understand that I can contact the practice at 845.647.4171. I hereby give Eclipse Physical Therapy and Wellness permission to perform physical therapy as prescribed by my physician on myself or my child (if applicable).

_____ ____/____/_____

Signature of patient (or legal guardian) **Date**