BODY RESTORATION PHYSICAL THERAPY, PLLC

200 S. Service Rd Suite 209
Roslyn Heights, NY 11577
Office 516-399-2503 Fax 516-908-3999

Patient name: _____

Street address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Date of birth: _____ Drivers License #: _____

Sex: M F O Pronouns _____ Marital status: _____

Home phone: ( ) _____ Cell phone: ( ) _____

Work phone: ( ) _____ Email: _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Phone: ( ) _____

REFERRING PHYSICIAN:

Name: _____ Phone: ( ) _____

Is it okay to contact you via: *(please check all that apply)*

___ Text message ___ Email ___ Voice mail

Body Restoration Physical Therapy, PLLC does not accept insurance, however we can provide you with a superbill, for private insurance companies only, after your treatment.

Body Restoration Physical Therapy, PLLC makes no guarantees as to the amount or payment frequency of reimbursements from your private insurance company.

SIGNATURE: _____ *DATE:* _____

BODY RESTORATION PHYSICAL THERAPY, PLLC

Privacy Policy

Patient Name: _____

Date of birth: _____

For services furnished to me by the providers of Body Restoration Physical Therapy, PLLC. I authorize Body Restoration Physical Therapy, PLLC to release appropriate information, medical or otherwise, as provided for by the HIPAA Privacy Rule, to my insurance carrier and its agents as needed to determine those benefits payable for related services **only in cases in which the patient has initiated contact with the insurance company.**

I understand that Body Restoration Physical Therapy, PLLC is compliant with HIPAA's Privacy Rule and that they adhere to the rules and regulations with regard to my medical records, or Protected Health Information (PHI). I consent to my PHI being used, disclosed and obtained as described above.

SIGNATURE: _____ *DATE:* _____

Patient name: _____ **Date of birth:** _____

Male Female Non-Binary/Other

Height: _____ **Weight:** _____

Past medical history: *(circle any that apply)*

Arthritis	Diabetes	Dementia
Osteoporosis	Embolism	Pneumonia
High Blood Pressure	Vestibular d/o	A-Fib
Cholesterol	Obesity	Depression
Cancer	Thrombosis	COPD
Back Dysfunction	Congestive Heat Failure	PVD

Other: _____

What is your chief complaint? _____

When did this issue begin? _____

How did this issue begin? _____

Have you received treatment for this before? _____

Have your symptoms: Improved Worsened Remained the same

What are your goals for PT? _____

Pain/Discomfort *(circle one)*: 0 (no pain) 1 2 3 4 5 6 7 8 9 10 (severe pain)

Location of Pain: _____

Type of Pain *(circle applicable)* : Sharp Shooting Stabbing Dull/Achy
Pins/Needles Numbness Pressure Heaviness

Surgeries: _____

_____

Medications/Vitamins/Over-the-counter medications:

Name	Dosage	Frequency	Administrated *ie. oral, patch, etc.*

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NO SHOW/Cancellation Policy

A 24 hour advance cancellation notice is required or you will be subject to a $65 cancellation fee. In case of cancellations that are made less than 4 hours ahead of the scheduled appointment time that cannot be allocated to another patient, or if the appointment is missed with no notice at all you will be charged the full session rate.

(COVID-19 Exceptions)

NOTE: In the event of a No Show, all of your future appointments will be automatically canceled.

Thank You

Print Name: _____

Signature: _____

Date: _____