Facility Use Only	
Date of Evaluation:	Therapist:

Patient Authorization

Patient Name:

Release of Information & Consent for Treatment

All information provided herein is true and correct.

I am aware of my diagnosis and wish to receive treatment at Upstate Physical Therapy (UPT), LLC. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care.

I give permission to UPT, LLC and its affiliates to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment.

I authorize UPT, LLC and affiliates to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

The signature below certifies that I have read and understand the above information.

Patient or Guardian Signature:	Date:

Assignment of Benefits

I authorize payment directly to UPT, LLC, its subsidiaries and/or affiliates for services.

This is a direct assignment of my rights and benefits under this policy.

A photocopy of this assignment shall be considered as effective and valid as the original.

Patient or Guardian Signature:	Date:

Notice of Privacy Practices (HIPAA Acknowledgement/Consent)

I hereby acknowledge that I have received a copy of The Notice of Privacy Practices for UPT, LLC.
In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and health care operations.

Patient or Guardian Signature:	Date:

Payment Guarantee

I agree to pay UPT, LLC. for the services provided to me or the party named above. If any law, such as workers' compensation, or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.

The Benefit Verification form is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment for services.

I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of UPT, LLC.

I also understand that if my account is sent to collections because of insufficient payment, that a 30% fee will be assessed to my account. This fee is to compensate for the cost of collecting my account.

I understand that Upstate Physical Therapy's policy is that a $40 no-show/cancellation fee may be charged to my account if notice is not given within 24 hours of my appointment.

Patient or Guardian Signature:	Date:

MEDICAL INFORMATION RELEASE FORM
HIPAA RELEASE

Patient Name: _____
Date of Birth: _____

RELEASE OF INFORMATION

( ) I authorize the release of information including the diagnosis, records, examination rendered to me and the claims information. This information may be released to :

( ) Spouse: _____
( ) Children: _____
( ) Other: _____

I authorize release of my information to my doctor and I give consent for my therapist to communicate with the doctor via phone/text/email. Yes:_____ No:_____

Please call ( ) my home ( ) my work ( ) my cell

If unable to reach me you may leave a detailed message: ( ) Yes ( ) No

Signed: _____ Date: _____

Upstate Physical Therapy

New Patient Information Sheet

Welcome to our practice!

Please help us serve you better by taking a few minutes to provide the following information.

Patient Information

Account #	Social Security #	Mr. Mrs. Ms.	Last Name	First Name	MI

Street Address (Road or Street) | (Apartment Number or Second Address Line)

Zip Code | City | State | How did you learn about our practice?

Home Phone: | Cell Phone: | Are you a former patient? ☐ Yes ☐ No

Birthday | Sex (M, F) | Referring Doctor full name

Marital	Employment	Student	Relationship to Insured
☐M-Married ☐ W-Widowed ☐S-Single ☐D-Divorced ☐ X-Separated	☐ R-Retired ☐ F-Full ☐P-Part ☐ N-None	☐ P-Part ☐ F-Full ☐ N-None	☐ SE-Self ☐ SP-Spouse ☐ OT-Other ☐ CH-Child

Emergency Contact Name | Emergency Contact Phone #

Patient Employer Name | Patient Employer Street Address (Road or Street)

Zip Code | City | State | Business Phone | Ext

INSURANCE INFORMATION

Primary Insurance Company Name | Mailing Address

Insurance Telephone # | Policy # | Group #

Secondary Insurance Company Name | Mailing Address

Secondary Telephone # | Policy # | Group #

COMPLETE IF INSURANCE IS IN SPOUSE'S/PARENT NAME

Social Security # | Title | Last Name | First Name | MI

Birthday | Sex (M, F) | Relationship to Insured:

ACCIDENT DETAILS- Please complete if visit is due to injury

Employment related: ☐ Yes ☐ No | Accident Related: ☐ Auto ☐ Other ☐ No | Date of first symptom or accident:

Give Details of Accident:

I authorize the release of any medical or other information necessary to process insurance claims.

Signed | Date

I authorize payment of medical benefits directly to this practice for the services rendered.

Signed | Date

UNIVERSAL MEDICATION FORM

Name:	Address:
Phone Number:	
Birth Date:	
Emergency Contact/Phone numbers:	

IMMUNIZATION RECORD (Record the date/year of last dose taken, if known)		
TETANUS	FLU VACCINE(S)	
PNEUMONIA VACCINE	HEPATITIS VACCINE	OTHER

Allergic To / Describe Reaction:	Allergic To / Describe Reaction:

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: Prescription and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, gingko). Include medications taken as needed (example: nitroglycerin).

DATE STARTED	NAME OF MEDICATION / DOSE	DIRECTIONS: Use patient friendly directions. (Do not use medical abbreviations.)	DATE STOPPED	Notes: Reason for Taking / Doctor Name