Physical Therapy Associates of Schenectady, P.C.

NAME: (Last) ______________________________ (First) ______________________________

STREET ADDRESS: ______________________ CITY: ________________ STATE: ______ ZIP: ________

EMAIL: ______________________________ PHONE: (H) ________________ (C) ________________

DOB: ____ / _____/ _____ SEX: MALE / FEMALE MARRIED: Y / N

REFERRING PHYSICIAN: ____________________ OFFICE LOCATION: ____________ PHONE: ____________

PRIMARY PHYSICIAN: ____________________ OFFICE LOCATION: ____________ PHONE: ____________

EMERGENCY CONTACT: ____________________ RELATIONSHIP: ____________ PHONE: ____________

REFERRED BY: DOCTOR / FRIEND / FAMILY / OTHER: ______________________________________

- **Have you EVER been treated for this body part as a result of a Worker's Compensation or No–Fault injury?** YES/NO
  If yes, when? ___________
- **Are you currently receiving ANY type of treatment from a certified home healthcare agency?** YES / NO
- **Have received any physical therapy or chiropractic care for the same body part this year?** YES / NO

*If you have answered **YES** to any of these questions, please notify the front desk*

Direct Access (Self-referred)
Notice of Advice

I understand that physical therapy may not be a covered service by my healthcare plan or insurer without a prescription from a physician, dentist, podiatrist, or nurse practitioner. It is my responsibility to determine if a prescription is required by my insurer in order to cover my physical therapy services. I understand that direct access to physical therapy is limited to **10 visits within 30 days from the initial treatment date.** I authorize physical therapy treatment to be provided by:

Physical Therapist Signature: ______________________________
Service Address: ______________________________
____

____
Patient's Signature

____
Beginning Date of Service

OFFICE USE ONLY:

Revision Date: ________________
Signature: ____________________