247 3rd Ave, Suite: LL2, New York, NY 10010
Ph: 212-598-5913 • Fax: 212-598-5914
gramercypt247@gmail.com

PATIENT REGISTRATION FORM

Press the Tab Button to move to next field. Click to change any box option.

GENERAL INFORMATION

Patient's Name: ____
Last Name First Name Middle I.

Street: ______________________________ Apt. ______________

City: ______________ State: ______________ Zip: ______________

Home Phone #: ______________ Work #: ______________ Cell #: ______________

Date of Birth: MM: ________ DD:________ YYYY:________ Age: ______ Sex: Female Male

Social Security# : ______ - ______ - ______ Marital Status: Single Divorced Married Widowed

Employer: ______________________ Occupation: ______________________

Employer's Address: ______________ City: ______________ State: ______________ Zip: __________

Emergency Contact: ______________________ Tel. # ______________ Cell# ______________

Address: ______________________ City:______________ State: ______________ Zip: __________

Email Address: ____

Have you had Physical Therapy at any other facility for this calendar year: Yes No If yes, # of visits? ______________

If yes, please list facility: ____

Is this injury the result an - Auto Accident: Yes No Work Accident: Yes No

REFERRAL & DOCTOR INFORMATION

How did you hear about us? Google Yelp Facebook Your Doctor (please list below) Family or Friend (please list below)

Referring Doctor's Name: ______________________ Family or Friend's Name: ______________________

Address: ______________________________ Phone #: ______________

City: ______________ State: ______________ Zip: __________ Fax #: ______________

Who is your General Medical Doctor: ______________________

Address: ______________________________ Phone #: ______________

City: ______________________ State: ______________ Zip: ______________

Patient's Signature: ______________________ **Date:** ______________

Initials: __________
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INSURANCE INFORMATION

Patient's Name: ____
Last Name First Name Middle I.

Primary Insurance Company: ____________________ ID/POLICY #: ____________________

Plan Name: ____________________ Group #: ____________________

Mailing Address: ____

City: ____________________ State: ____________ Zip: ____________

Insured Name (if other than Patient): ______________________________

Relationship to the insured: Self Spouse Child

Secondary Insurance: ____________________ ID/Policy#: ____________ Group#: ____________

Relationship to the insured: Self Spouse Child

CREDIT CARD PAYMENT AUTHORIZATION (Optional)

I hereby authorize Gramercy Physical Therapy PC to charge my credit card for services rendered and/or products supplied for a period of one year from the date below. It is my responsibility to notify Gramercy Physical Therapy PC any changes regarding this credit card authorization.

Name on Card: ______________________________

Credit Card Type: MasterCard Visa American Express Discover

Credit Card Number: ______________________________ Expiration Date: ____________

Security Code: ________ Billing Zip Code: ____________

Patient's Signature: ____________________ Date:______ / ______ /______ Initials: ____________

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MEDICAL HISTORY

Please check the appropriate response:

NO YES Are you in good general health?

NO YES Are you now taking any drugs or medications?

If yes, which ones? ______________________

NO YES Are you allergic to any medications?

If yes, which ones? ______________________

Family Doctor: ______________________

Phone: ______________________

NO YES Would you object to our office contacting your family doctor in regard to any medical problem that may arise?

NO YES Do you take aspirin products or anti-inflammatory medicines or headache medicines?

Which ones? ______________________

NO YES Do you exercise regularly?

PLEASE LIST ALL PREVIOUS SURGERIES AND DATES:

____

____

HAVE YOU HAD:

NO YES Blood pressure or related issues
NO YES Diabetes
NO YES Liver or gallbladder problems
NO YES Hepatitis
NO YES Heart trouble
NO YES Kidney disease
NO YES Stomach problems
NO YES Bleeding tendency
NO YES Any part of your body paralyzed
NO YES Psychiatric consultation
NO YES Epilepsy-convulsions or seizures
NO YES Broken bones of the face, neck, jaw
NO YES Back trouble
NO YES Abnormal chest x-rays
NO YES Abnormal Electrocardiogram
NO YES Asthma
NO YES Nervous conditions
NO YES Herpes or cold sores
NO YES Trouble breathing
NO YES Urinary symptoms
NO YES Arthritis
NO YES Any rheumatic disorder
NO YES Unexplained fever
NO YES Skin rash

Other: ______________________

DO ANY FAMILY MEMBERS HAVE: (Check if yes)

Heart trouble
Excessive scarring
Diabetes
Adverse reactions to anesthesia
Tuberculosis
Excessive bleeding tendency
Psychiatric or "nerve" problems
Arthritis

DO YOU:

NO YES Wear contact lenses
NO YES Have dentures or false teeth
NO YES Smoke? How much? ______________________
NO YES Drink alcohol? How much? ______________________
NO YES Think you are pregnant

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INFORMED CONSENT FORM

1. **Consent to Physical Therapy Treatment**
   I hereby authorize the staff of Gramercy Physical Therapy PC to administer physical care to me. I understand that my treatment plan may be modified from time to time based on my progress relative to established treatment goals
2. **Information Release Authorization**
   I hereby authorize Gramercy Physical Therapy PC to release any and all of my medical records to any parties requesting information such as, and including, any physician and/or healthcare professional involved in my care, any insurance company from which I am seeking to receive payment for medical bills, my legal representative, and any other party or parties requesting my medical records via subpoena or court order.
3. **Authorization to Make Direct Payment for Medical Services**
   I hereby authorize my insurance company(ies) to make payment directly to Gramercy Physical Therapy PC for monies owed to them for services rendered to me.
4. **Cancellation Policy**
   It has been explained to me and I understand, that I am responsible to attend each one of my scheduled appointments. I further understand that should I not be present for or cancel my scheduled appointment without 24 hour notice, I may be assessed a $75.00 visit cancellation fee payable prior to my next scheduled visit.
5. **Patient Payment Responsibility**
   I understand and agree that should my health plan require to me to pay a co-payment for physical therapy services rendered to me, then I shall make payment at the time the service is delivered. Further, I understand that I am personally responsible for all charges for services rendered to me by Gramercy Physical Therapy PC. I agree to pay an interest fee of 1.5% per month on any outstanding balance on my account
6. **Patient Payment Return Responsibility**
   I understand and agree that should my health plan send payment checks for physical therapy services directly to my address, then I shall deliver those checks to Gramercy Physical Therapy or repay the equal amount via Money App within 30 days from their receipt.
7. **Consent to Treatment of a Minor Child**
   I hereby attest that I am the legal custodian of the minor child named below and authorize the staff of Gramercy Physical Therapy PC to administer care as they deem necessary to my:
   (Check one)

Son Daughter Nephew Niece Brother Sister Other: ______________________________

Name of minor child: ____

I have read, understand, and agree to the above terms and conditions. My signature acknowledges my agreement and full understanding of the above information.

Signature: _________________________________ **Date:** _______________________________

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PATIENT FINACIAL LIABILITY FORM

Please understand that full payment of your account/bill is considered part of your treatment and is required for all services rendered. Also understand that payment of past services rendered and treatment given is required before all future services and treatment may be given. We accept full payment at the time the services are rendered. This office accepts Visa, Mastercard, American Express, and Discover. Checks are accepted with a valid photo ID. Returned checks are subject to additional service fee. Extended payment plans may be offered with PRIOR credit approval and PRIOR patient request. All unpaid accounts are to collection after payment is not made in a reasonable time period and may adversely affect your credit. Non-emergent medical services can be denied for unpaid accounts.

INSURANCE IS ACCEPTED UNDER THE FOLLOWING CONDITIONS:
All co-payments are due at the time of service. Patient agrees to pay all deductibles, coinsurance, and services deemed “patient responsibility” as identified by the insurance carrier. Deductibles, coinsurance, and patient portions are billed monthly on receipt of the patient’s insurance statement from the insurance carrier regarding your patient claim. **YOU**, the patient, are responsible to render payment once billed for the remainder. Patients are fully responsible for obtaining all necessary referral from another physician before the appointment time. Claim payments denied due to lack of referral becomes the patient’s responsibility.

Although we make every effort to obtain accurate information the insurance carrier, verification of benefits is not a guarantee that the insurance carrier will pay a claim. The insurance carrier makes the final determination based upon plan’s level of coverage and associated policies upon receiving the claim. Denied claims become the responsibility of the patient.

I have read the above information and agree to the terms contained therein.

Patient’s Signature:____________________________ **Date:** ____________________________