Maccio Physical Therapy, PLLC

Joseph G. Maccio, PT Dip. MDT
Joseph R. Maccio, DPT, Dip MDT
Lindsay Carlton, ATC, DPT, Dip. MDT
Matthew Myers, DPT

1 New Hampshire Ave.
Troy, NY

(518) 273-2121

Certified McKenzie Spine and Extremity Clinic

Name: _____ Sex: Male / Female / Other_____
Date of Birth: _____ / _____ / _____ Pronouns: She/Her He/Him They/Them O: _____
Address: _____ Marital Status: S / M / D / W / _____
City: _____ State: _____ Zip: _____ SSN: _____-_____-_____
Home Phone: (_____) _____-_____ Email: _____ ***Reminders**: Text or Email*_____
Work Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____ Wireless Carrier: _____

Emergency Contact:
Name: _____ Phone: (_____) _____-_____ Relationship: _____

Patient History
Are you currently receiving home healthcare? Y / N
Are you currently receiving speech therapy? Y / N
Have you had or are you currently receiving **chiropractic care** this year? Y / N
Have you had any previous Physical Therapy by **any other provider in the last year**? Y / N
Is this injury Work-related or Motor vehicle-related? Y / N If yes: Date of Injury:_____
Are you a returning Patient? Y / N If yes, please indicate the year: _____
Primary Physician: _____ **Referring Physician**: _____
How did you hear about us? Physician Referral / McKenzie Institute / Friend or relative: _____
Advertisement: Advertiser / Phone Book / Internet: _____ Other: _____
Employment: FT / PT / Self / Other: _____
Name: _____ Job Title: _____
Address: _____ Suite: _____
City: _____ State: _____ Zip: _____

Insurance
Is this work or motor vehicle-related? Y / N If yes Date of Injury: _____ / _____ / _____
Primary Insurance: _____ ID Number: _____
Subscriber information (*if different from your own*)
Subscriber Name: _____ Subscriber Date of Birth: _____ / _____ / _____
Address: _____ City: _____ State: _____ Zip: _____
Relation to Patient: Self / Spouse / Parent / Other: _____

Secondary Insurance ID Number: _____
Subscriber information (*if different from your own*)
Subscriber Name: _____ Subscriber Date of Birth: _____ / _____ / _____
Address: _____ City: _____ State: _____ Zip: _____
Relation to Patient: Self / Spouse / Parent / Other: _____

I authorize the release of any information necessary to process my insurance claims, assign payments directly to my physician, and acknowledge that I am responsible financially for any unpaid balance. I assign all medical/surgical benefits to include, but not limited to BlueShield & Empire Blue Cross/Blue Shield to Maccio Physical Therapy. Payment of Medicare Benefits, I request that payment of Medicare benefits be made to Maccio Physical Therapy for services furnished to me by that practitioner.

I authorize any holder of medical information about me to be released to the Healthcare Financing Administration and its agents any information needed to determine benefits payable for related services and acknowledge that I am financially responsible for any unpaid balance for related services.

Signature: _____ Date: _____
(Of parent/ Guardian if under 18)

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General Medical History

Name: _____ Referring Physician: _____
Emergency contact: _____ Relationship: _____
Contacts home phone: _____ Contacts work phone: _____
Please circle if you are allergic to any of the following: Chlorine Iodine
Other allergies: _____
Current Medications (include dosage): _____
_____

What is the average intensity of your symptoms?

Please circle any of the following which applies to you. Please explain any circled responses in the space below.

Arthritis	Headache	Pins and Needles
Asthma	Hearing Difficulties	Pneumonia
Blood Disorders	Heart Attack	Pregnant (Currently)
Cancer	Hepatitis	Seizures
Chest Pain	High/ Low Blood Pressure	Sprain / Strain
Cyanosis	High / Low Pulse	Stroke
Diabetes	HIV+/ AIDS	Swelling
Dizziness	Inhaler	TB
Emphysema	Joint Pain	Tremor
Faint Feeling	Joint Replacement	Varicosities
Fracture	Numbness	Visual Problems
Gastrointestinal	Pace Maler	Weakness
Genito-Urinary	Paralysis	Other: _____

EXPLANATIONS:_____
_____

I acknowledge that the above information is correct to the best of my knowledge.

Patient (or Guardian) Signature: _____ Date: _____

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CONSENT TO TREAT, CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION, AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Maccio Physical Therapy, PLLC (the "Provider") Effective Date: _____

1. **Patient Consent to Treat**
   I, the undersigned patient, consent to such treatment procedures as are deemed necessary by the Provider including those which are in addition to or different from those initially contemplated, and which are deemed necessary or advisable by the Provider in the course of treatment.

2. **Patient Consent for Use and disclosure of Protected Health Information ("PHI")**
   I, the undersigned patient, give my consent to the Provider entity and its agents to use or disclose my protected health information ("PHI") to carry out our treatment, or health care operations. These individuals and entities can release, use, or disclose my PHI to other health care personnel including but not limited to physicians, certified registered nurse anesthetists, anesthesia assistants, nursing staff, nurse practitioners, physicians' assistants, child life specialists, physical therapists, respiratory therapists. X-ray personnel, audiologists, students in each of the above disciplines, and such entities or persons as are deemed related to treatment, payment, and health care operations, as determined in the sole discretion of the Provider, his / her practice group, and their respective agents.
3. **Permission to Release Medical Records to Providers**
   If another provider who is involved with treatment, payment, or health care operations relating to me requests medical records, I consent to release my entire medical record maintained by the Provider to those other providers. I also consent to have other facilities release any X-ray, Op notes, IME reports requested by this Provider.
4. **Permission to Release Billing Information Over the Telephone**
   I agree, as part of this consent for payment operations, that the Provider, its group and their billing personnel, billing agents, or management company can disclose billing information to any persons that calls the Provider with billing questions after the provider inquires as to the identity of the calling person and the calling person provides any correct social security number or health plan number.
5. **Permission to Call and Leave Voice Mail Messages**
   I agree that the Provider or its agents or representatives may call and leave a voice mail message at my home or other number I provide them regarding medical appointments, billing or payment issues, or other information related to treatment, payment, or health care operations.
6. **Permission to Email**
   I grant permission to the Provider to e-mail to my home or other alternative location, any time that assist the practice in carrying out TPO. *My e-mail address is the following*:

_____

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7. **Permission to Discuss Protected Health Information with Third Persons**
   I agree that the Provider may discuss my PHI with any person that accompanies me to a visit or procedure or is present with me when the Provider is present. The Provider may rightly assume that if the other person is with me, I have no objection to disclosure of my PHI to that person. I also agree the Provider may discuss my PHI with any person that identifies him to herself as active in my mental, physical, emotional, or spiritual care, including by not limited to family, friends, clergy, and patient advocates. I also agree that the Provider, his / her practice group, and their agents may disclose my PHI to employers who arrange and pay, directly or indirectly, for my medical treatment.
8. **Permission to Discuss Protected Health Information Regarding Minors**
   I agree that the Provider, his / her practice group, and their agents may discuss my child's PHI with the person accompanying the child. I agree that the Provider may discuss PHI with both natural parents and stepparents. I acknowledge that state law may grant my child certain privacy rights regarding the child's PHI, and that I have no right to receive this information.
9. **Permission to Discuss Protected Health Information with Public Agencies**
   I agree that the Provider, his / her practice group, and their agents may, upon request by the following entities, disclose my PHI to public health agencies, law enforcement, and the FDA.
10. **Acknowledgement of Receipt of Notice of Privacy Practices**
    I acknowledge that I have received from this Provider a copy of a separate document, entitled, "Notice of Privacy Practices" which sets forth this provider's privacy practices and my rights regarding privacy of my PHI. The terms of the "Notice of Privacy Practices" may change. If the Provider changes its "Notice of Privacy Practices," I understand I may obtain a revised copy by contacting the Provider's office. A Copy of this "Notice of Privacy Practices" is located in the waiting room and is available to me at any time. I understand that I have the right to review this "Notice of Privacy Practices" prior to signing this consent.
11. **Right to Restrict Protected Health Information; Right to Revoke Consent**
    I understand that I have the right to request that the Provider restrict how my PHI is used or disclosed for treatment, payment, or healthcare operations and that the Provider is not required to agree to this restriction. If the Provider does agree to the restriction, however, the Provider is bound by such agreement. I also understand that I have the right to revoke this consent, in writing, except where the Provider has already made disclosures in reliance on my prior consent.

_____ _____

Patient Signature or Personal Representative Date

_____

Relationship, if Personal Representative

Name of Entity: Maccio Physical Therapy, PLLC
Address: 1 New Hampshire Avenue
City & State: Troy, New York 12180
Telephone: (518) 273-2121
Fax: (518) 273-0701

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PATIENT APPOINTMENT POLICY

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well-being and the gain of your physical abilities is something everyone in our clinic takes quite seriously.

Our best outcomes occur when patients complete their treatment plans. Your adherence to the recommended number of treatments is a vital component of your progress with services.

We expect you to keep all your appointments with the exception of illness or serious emergencies. Please be on time for your appointments. Write down the time of your visits so you do not forget.

If you need to reschedule an appointment for any other reason, we do *require 24-hour notice*. In such a case, please call our office and arrange for a make-up appointment with our Front Desk Receptionist. In an instance you cancel without the 24-hour notice or no-show to a scheduled appointment, we reserve the right to charge you a $25 fee after the second warning.

If you continue to be non-compliant with your scheduled visits, you will be placed on a “call on the day of treatment” schedule. We also reserve the right to discontinue care and will inform your physician of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

Joseph G. Maccio, MA, PT, Dip.MDT

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I have read and understand the policy _____Date_____

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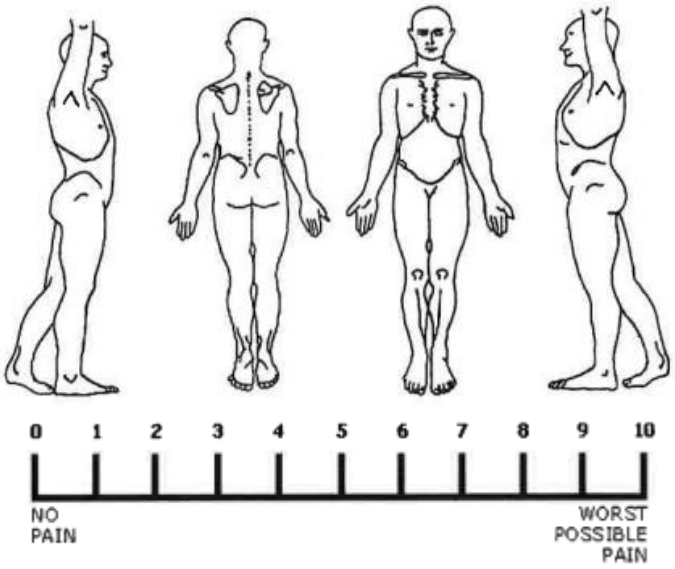
How are you feeling today?

Patient Name: _____ Date: _____

1. **Describe your Symptoms**:_____
   _____
   a. **When did your symptoms start?** _____
   b. **How did your symptoms start?** _____
2. **How Often do you experience your symptoms?**
   a. Constantly (76-100% of the day)
   b. Frequently (51-75% of the day)
   c. Occasionally (26-50% of the day)
   d. Intermittently (0-25% of the day)
3. **What is the nature of your symptoms?**
   a. Sharp d. Shooting
   b. Dull Ache e. Burning
   c. Numb f. Tingling
4. **How are your symptoms changing?**
   a. Getting Better
   b. Not Changing
   c. Getting Worse
5. **During the last 4 Weeks indicate the average intensity of your symptoms on the scale:**

Indicate on the diagrams where you have pain or other symptoms



6. **During the past 4 weeks how much has pain interfered with your normal work? (Outside of the home and household)**
   a. Not at All b. A Little Bit c. Moderately d. Quite a Bit e. Extremely
7. **What are you unable to do because of your current condition?**
8. **To what degree is this important to you?**
9. **How does this condition affect your livelihood?**
10. **Do you think physical therapy can help you?**
11. **What results do you hope to see from physical therapy?**

For Medicare Patients Only

1. **Have you had 2 or more falls in the past year?**
   Yes No
2. **Have you had any falls resulting in injury?**
   Yes No

Therapist Initials_____
Date_____