



# Comprehensive Physical Therapy Associates

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*www.ComprehensivePhysicalTherapy.net*

## General Information

Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
Date of Birth (MM/DD/YYYY) \_\_\_\_/\_\_\_\_/\_\_\_\_ Current Age \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Phone: Home \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Office \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ ext. \_\_\_\_\_  
Mobile \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ E-mail \_\_\_\_\_

## Referral/Diagnosis

Primary Care Physician \_\_\_\_\_  
Referring Physician \_\_\_\_\_  
Diagnosis \_\_\_\_\_  
Describe your symptoms/condition in your own words \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Current Health/Past Medical History

Do you currently or have you ever suffered from any of the following:  
Y  N  **Diabetes** Y  N  **Heart condition** describe: \_\_\_\_\_  
Y  N  **High blood pressure** Y  N  **Lung condition** describe: \_\_\_\_\_  
Y  N  **Dizziness** Y  N  **Cancer** where & when: \_\_\_\_\_

Please list any other medical conditions that we should know about: \_\_\_\_\_  
\_\_\_\_\_

Women, are you currently pregnant? Y  N

If you currently take any medications, please list their names and what they are for:

Name: \_\_\_\_\_ For: \_\_\_\_\_  
Name: \_\_\_\_\_ For: \_\_\_\_\_  
Name: \_\_\_\_\_ For: \_\_\_\_\_  
Name: \_\_\_\_\_ For: \_\_\_\_\_

If you have ever had surgery, please list type of surgery and date:

Type of Surgery: \_\_\_\_\_ Date: \_\_\_\_\_  
Type of Surgery: \_\_\_\_\_ Date: \_\_\_\_\_  
Type of Surgery: \_\_\_\_\_ Date: \_\_\_\_\_

Have you had physical therapy for *this* condition before? If so, list when, where, and the number of treatments you received \_\_\_\_\_  
\_\_\_\_\_

**Note:** If you have had any physical therapy this year, it is important to tell us how many visits you have had to date. This will determine how many visits you will have available based on your physical therapy benefit limitation. **PLEASE COMPLETE OTHER SIDE...**

## *Insurance Information/Authorization to Pay*

Primary Insurance \_\_\_\_\_ Name of Insured \_\_\_\_\_

Is the insured  Yourself, or  Other? *If Other, please specify relationship to you:* \_\_\_\_\_

Social Security/Medicare # \_\_\_\_\_

Secondary Insurance \_\_\_\_\_

Person to notify in case of emergency \_\_\_\_\_

Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Relationship to you \_\_\_\_\_

***I request that payments be made on my behalf to Comprehensive Physical Therapy for services furnished to me by the provider. I authorize the release of any information needed to process my claims for payment.***

Signature \_\_\_\_\_

Date: (MM/DD/YYYY) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

## *Notice of Patient Information Practices*

***I, the undersigned, hereby acknowledge that Comprehensive Physical Therapy Associates, P.C. has provided me with the HIPPA form regarding the uses and disclosures of my health information and individual rights as a patient.***

Signature \_\_\_\_\_

Date: (MM/DD/YYYY) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

## *Notice of Cancellation Policy*

Cancellations MUST be made AT LEAST 24 HOURS prior to your scheduled appointment. A \$40 fee will be charged for no shows or late cancellations. Please note that this fee is not reimbursed by your insurance.

***I, the undersigned, hereby state that I am aware of the 24-hour cancellation policy.***

Signature \_\_\_\_\_



*We'll get you moving in the right direction*  
**www.ComprehensivePhysicalTherapy.com**