(516) 487-9810
www.marathonptny.com
info@marathonptny.com

Patient Intake Form

Date______________________

- ☐ Scan Insurance Cards
- ☐ Rx for P.T. signed by MD

PATIENT GENERAL INFORMATION

Last Name		**First Name**		**Middle Initial**	
Address				Apt. Number	
City/Town		State		Zip code	
Home Phone		Cell Phone		Email	
Best way to contact you	☐Home Phone ☐Cell Phone ☐Text ☐Email				
Social Security		Date of Birth		Age	
Height		Weight		☐Male ☐Female	☐Single ☐Married
Work Status	☐Currently Employed ☐Retired ☐Full Time Student ☐Part Time Student ☐Permanently Disabled ☐Temporarily Disabled				
Employer Name		Business Phone		Occupation	
Employer Address					
City/Town		State		Zip code	

Emergency Contact		Relationship		Phone	
If patient is a minor, Parent or Guardian Name					
If patient is a minor, Parent or Guardian Signature					

How did you hear about us?	☐Friend or Family ☐Internet ☐Advertisement ☐Insurance Directory ☐Brochure ☐Physician (provide details) ☐Other (provide details)		
Physician Name		Physician Phone	
Physician Address			
City/Town		State		Zip code	

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INSURANCE INFORMATION

Primary Insurance Company				Phone	
Name of Insured				ID #	
Secondary Insurance Company				Phone	
Name of Insured				ID #	
If patient is covered by someone else's policy, provide their information here					
Last Name		First Name		Middle Initial	
Address				Apt. Number	
City/Town		State		Zip code	
Social Security		Date of Birth		Relationship	
Employer Name		Business Phone		Claim #	
Employer Address					
City/Town		State		Zip code	

INJURY INFORMATION

Injury Type	☐Personal ☐Auto (No-Fault) ☐Work ☐ No Injury			Incident Date	
Details					
Additional Information (if relevant)		Employer's HR Contact		Phone	
Insurance Adjuster Name				Phone	

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INSURANCE ASSIGNMENT

I hereby instruct and direct my insurance company to pay by check made out to, and mailed to:

Marathon Physical Therapy of NY
556B Middle Neck Rd
Great Neck, NY, 11023
(516) 487-9810

If my current policy prohibits direct payment to the Marathon Physical Therapy of NY, I hereby also instruct and direct my insurance company to make out the check to me and mail it to the address above (not mine) for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for the professional services rendered.

Patient Signature: ________________________________ **Date:** ________________________________

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

This payment will not exceed my indebtedness to Marathon Physical Therapy of NY, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

Check each box, then sign at the bottom:

- ☐ I hereby grant my authorization and consent to such examination(s), treatment(s) as deemed necessary by the therapists at this facility.
- ☐ A photocopy of this Assignment shall be considered as effective and valid as the original.
- ☐ I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
- ☐ I authorize the use of this signature on all insurance submissions.
- ☐ I authorize Marathon Physical Therapy of NY to deposit checks made in my name.
- ☐ I authorize Marathon Physical Therapy of NY to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

I CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE, AND THAT I WILL BE RESPONSIBLE FOR PAYMENT OF SERVICES **NOT** COVERED BY MY INSURANCE COMPANY.

Patient Signature: ________________________________ **Date:** ________________________________

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CO-PAY / CO-INSURANCE

Managed Care Contract Compliance (if applicable)

We are obligated to collect co-payments / co-insurances each and every visit that requires one. It is considered fraud by us to collect from some patients and not from others. Our intention is to support you by providing the highest quality of care and assist you with your insurance plan. We would never want to jeopardize your insurance by not collecting your co-payment / co-insurance.

We accept checks (including post-dated checks), cash, and most major credit cards.

Patient Signature: ____ **Date:** ____________________________________

NOTICE OF PRIVACY PRACTICE

I acknowledge that I was provided with a copy of the Notice of Privacy Practice and that I have read (or had the opportunity to read if I so choose) and understood the notice.

Patient Signature: ____ **Date:** ____________________________________

CANCELLATION POLICY

We kindly ask of you to give us at least 24 hours' notice for any cancellations or changes to your scheduled appointment time.

A **$25.00 fee** will be applied for any missed and cancelled appointments that occur without a 24-hour notice.

I CERTIFY THAT I WILL BE RESPONSIBLE FOR PAYMENT OF $25 FOR ANY MISSED/CANCELLED APPOINTMENTS WITHOUT A 24-HOUR NOTICE.

Patient Signature: ____ **Date:** ____________________________________

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PATIENT HEALTH INFORMATION

Please list all allergies

Please list all medications and prescriptions

Please list any surgeries

Are you a smoker?	☐Yes ☐No	If so, for how long?	

Do you currently have or have you ever had any of the following symptoms related to your injury?					
Numbness or Tingling	☐Yes ☐No	Difficulty Sleeping	☐Yes ☐No	Difficulty Urinating or Controlling Bladder	☐Yes ☐No

Please indicate if currently have or have you ever had any of the following medical conditions?		
☐ Arthritis	☐ Dizziness/Fainting	☐ Pacemaker
☐ Artificial Joint(s)	☐ Emphysema	☐ Post Menopause
☐ Asthma	☐ Heart Problems	☐ Seizures/Epilepsy
☐ Blood Disorder	☐ Heartburn/Indigestion	☐ Stomach Problems
☐ Cancer	☐ Hepatitis	☐ Stroke
☐ Circulation Problem	☐ High Blood Pressure	☐ Tremors
☐ Diabetes	☐ High Cholesterol	☐ Tuberculosis
☐ Difficulty Breathing	☐ Kidney Disease	☐ Unexplained Weight Loss/Weight Gain
☐ Difficulty Swallowing	☐ Osteoporosis	

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If you have had **Physical Therapy**, please provide details including when and where.

If you have had **Home Healthcare**, please provide details including when.

If you have had **Other Care,** please provide details including when and where.

Please share any additional information.

Patient Signature: ________________________ **Date:** ________________________