Mary Lou Corcoran Physical Therapy
Providing Individualized, Quality Patient Care

MARY LOU CORCORAN PHYSICAL THERAPY

Welcome to MLCPT! Please complete the following information thoroughly.

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Would you like to receive emailed reminders for your appointments (please circle)? Y N

Emergency Contact: _____ Phone #: _____

Emergency Contact: _____ Phone #: _____

How did you hear about us? _____ Are you a returning patient? Y N

Are you (please circle): Male Female Are you currently employed (please circle)? Y N

If yes, what is your occupation? _____ Employers Name _____

I authorize Mary Lou Corcoran Physical Therapy to discuss my medical information with the following:

Spouse: _____ Phone #: _____

Family Member: _____ Phone #: _____

Referring Doctor: _____ Phone #: _____

Primary Care Doctor: _____ Phone #: _____

Other (relationship): _____ Phone #: _____

I authorize MLCPT to leave a message regarding my physical therapy on my answering machine/voicemail (please circle)? Y N

Guardian Agreement (If patient is a Minor)

If the patient is a minor, I hereby authorize MLCPT to provide physical therapy services.

_____ _____
Signature of Parent/Guardian Date

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Primary Insurance: _____ Subscriber (please circle) Self Spouse Parent Other

Subscriber Name: _____ Subscriber Date of Birth: _____

Secondary Insurance: _____ Subscriber (please circle) Self Spouse Parent Other

Subscriber Name: _____ Subscriber Date of Birth: _____

The patient is responsible for notifying the front desk of any changes in insurance, plans, subscriber information, etc.

Under New York State Law, some insurance plans may allow a patient to seek physical therapy services without a prescription for ten (10) visits or thirty (30) days, whichever comes first. For further details please check with receptionist at the front desk.

Reason(s) for attending therapy: _____

Please check which of the following applies to your condition?

( ) Motor vehicle accident ( ) Work-Related injury ( ) Injury related to falling
( ) Recurrence of previous injury ( ) Athletic/Recreational injury ( ) Cause unknown
( ) Gradual Onset ( ) Other: _____

Is this condition post-surgical? Y N If yes, what type of surgery? _____

Have you schedule a follow up appointment with your referring doctor? Y N

If yes, what is the date of your follow up appointment? _____

Have you received any previous treatment for this condition? Y N

If yes, please list when and where? _____

Are you currently receiving chiropractic, occupational, physical or speech therapy? Y N

If yes, where and what injury is being treated? _____

If you answered yes to the above question, please let the front desk know. Some insurance plans do not allow these treatments at the same time.

Have you had any speech, occupational, home healthcare of physical therapy this year? Y N

If yes, who provided the care? _____ How many visits? _____

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Medical Conditions & Medications

The following information is required for your safety and by most insurance companies.

Do you or have you ever had any of the following (please circle):

Anxiety/Panic Disorder	Y	N	Hearing Impairment	Y	N
Are you currently pregnant	Y	N	Heart Attack/Heart Failure	Y	N
Asthma	Y	N	Heart Conditions	Y	N
Cancer	Y	N	High Blood Pressure	Y	N
Circulation Condition	Y	N	Infectious Diseases	Y	N
Covid-19	Y	N	Osteoarthritis	Y	N
Autoimmune Condition	Y	N	Osteoporosis	Y	N
Depression	Y	N	Pacemaker	Y	N
Diabetes Type I	Y	N	PTSD	Y	N
Diabetes Type II	Y	N	Respiratory Condition	Y	N
Dizziness/Fatigue	Y	N	Seizures	Y	N
Electronic Implant (s)	Y	N	Stroke	Y	N
Falls in Past Year	Y	N	Visual Impairment	Y	N
Headaches/Migraines	Y	N	Other (please explain):_____		

Height: _____ Weight: _____

Are you taking any medications now? Y N If yes, please list below or attach list.

Medication	Reason for Taking Medication

Do you have any allergies? Y N If yes, please list: _____

_____

Have you had any major illness, hospitalizations or surgeries in the last year? Y N
If yes, please list: _____

In the past month, have you been feeling down, depressed or hopeless or bothered by having little interest or pleasure in activities (please circle)? Y N

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Office & Financial Policies

Scheduling

Appointments are available Monday-Thursday 6:30 AM to 5:30 PM and Fridays from 6:30 AM to 3:30 PM. Appointments must be scheduled ahead of time and must be booked by the patient. There are no "standing appointments." Please arrive 5-10 minutes early for each appointment. If you are over 10 minutes late, the therapist will have the option of seeing you or asking you to reschedule your appointment to another time. **Please make sure that your voicemail is set up and is cleared periodically in the event that we may need to contact you.**

No Shows/Cancellation Policy

The success of your treatment is important to us. In order to have a successful treatment plan your attendance is imperative. Cancellations without adequate notice, within 12 hours of your scheduled appointment time, cannot be filled and take valuable time away from our therapists and other patients, thus they are subject to a $25 late cancel/no show fee. This fee must be paid prior to the start of the next appointment. Multiple "no shows" or late cancellations may result in the patient being discharged from our office.

Prescriptions

Prescriptions expire one (1) month from the date they were written unless otherwise specified. **Patients are responsible for maintaining a valid prescription** and for requesting an updated prescription every thirty (30) days or as needed. The front desk will inform you when your prescription is getting close to its expiration date.

Direct Access

Under New York State Law, some insurance plans may allow a patient to seek physical therapy services without a prescription for ten (10) visits or thirty (30) days, whichever comes first. For further details please check with the receptionist at the front desk.

Insurance Benefits

As a courtesy to patients we check your insurance benefits to the best of our ability. **However it is the patient's responsibility to know their insurance benefits**, including but not limited to copay/coinsurance, deductible, referrals, and visit limits. It is also the patient's responsibility to notify MLCPT when their deductible or out-of-pocket (if applicable) has been met. All balances, including copays, coinsurances, or deductible payments, are due at the time of service. I understand that if my insurance (including Workers Compensation and No Fault) does not cover my treatment then I will be responsible to cover the cost of the treatments.

The patient is responsible for notifying the front desk of any changes in insurance, plans, subscriber information, etc.

Thank you for choosing MLCPT for your treatment needs!
Please like us on Facebook & Instagram!

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HIPPA Policy

The HIPPA Privacy Rule requires that we make "reasonable" attempts to secure confidentiality and privacy in our healthcare environment. Due to an open floor plan "incidental disclosure" may occur in the normal course of quality care. Please refer to our Notice of Privacy Practices for further details. A copy of this policy is available upon request and is posted by the front desk.

I certify that I have been notified of MLCPT's HIPPA policy and I agree to seek treatment at this office with full knowledge of this policy.

_____ _____
Signature of Patient or Guardian Date

_____ _____
Print Name Front Desk Initials

Patient Agreement

I hereby certify that all the information I have provided to MLCPT is accurate at this time.

I certify that I have read and agree to the Office & Financial Policies listed above and I have received a copy of these policies for my own records. I understand that if my insurance (including Workers Compensation and No Fault) does not cover my treatment then I will be responsible to cover the cost of those treatments.

I hereby authorize MLCPT to use or disclose all information necessary for treatment, obtaining payment and health care operations.

I hereby authorize MLCPT to perform any medical treatment as deemed necessary under the New York State Physical Therapy Practice Act.

_____ _____
Signature of Patient (or Guardian) Date

_____ _____
Print Name Front Desk Initials

Thank you for completing MLCPT's intake paperwork. Please complete the attached tool form(s) with specific questions regarding your symptoms. If you have any questions please ask at the front desk.
Thank you for choosing MLCPT for your treatment needs!