Welcome to Fleming Physical Therapy Consultants (FPTC). Our Mission is to "Provide Patient Centered Physical Therapy Services that are of the Highest Quality Possible". We provide physical therapy services for a variety of diagnoses including musculoskeletal disorders, balance and dizziness disorders, work injury prevention and rehabilitation.

FPTC president and founder is Robert Fleming PT, DPT, OCS, FAAOMPT. Dr. Fleming has many years of experience in the field and has extensive credentials:

- Board Certified Clinical Specialist in Orthopedics—one of only a few in the region
- Fellowship Trained in Orthopedic Manual Physical Therapy—the only fellowship trained PT in the region
- Published Researcher with publications in peer-reviewed journals
- National lecturer on topics surrounding the management of musculoskeletal disorders

Providing you with a great experience and meeting your expectations is extremely important to us. In order to do this we participate in a team approach, with YOU being an important part of the team. You need to actively participate in your treatment in order to gain the most benefit.

Office Policies and Information:

Appointments: This time is set aside for you. Failing to show or canceling with short notice can adversely affect not only your care but the care of our other patients. We understand that unforeseen circumstances occur but we kindly request at least 24 hours notice as. Failure to show or late cancel for your appointment will result in a $75 fee. Payment is expected at the next appointment. If you fail to show for 2 appointments you will be discharged from our service.	Payment: At the time of your visit we will verify your insurance coverage. If you have coverage, your primary insurance will be billed by us. Deductibles, copays and cost shares will be due at the time of your visit.
Insurance referral/precertification: If your insurance requires either of these it is your responsibility to obtain one prior to your first visit. Without authorization you will be responsible for each visit not authorized. We will assist with this if required after the initial visit.	Questions: If you have any questions in regard to our office and/or your physical therapy treatment please ask your attending physical therapist and they will assist you.
Office Hours: Monday – Friday 8 am – 8 pm.	**I agree and fully understand the aforementioned policies:**_____

Fleming Physical Therapy Consultants PC

1401 Union St
Schenectady, NY 12308
518-346-0605

53 Arterial Plaza
Gloversville, NY 12078
518-921-4189

5010 State Highway 30
Amsterdam, NY 12010
518-212-6291

FLEMING PHYSICAL THERAPY CONSULTANTS PC

PATIENT REGISTRATION

Name:_____ Date:_____

Address:_____ Date of Birth:_____

City:_____ State:_____Zip:_____Email:_____

Telephone (H):_____ (W):_____ (C):_____

Social Security Number:_____Occupation;_____

Referring Physician:_____ Primary Care Physician:_____

Emergency Contact:_____ Telephone:_____

Address:_____ Relationship:_____

CONSENT FOR PHYSICAL THERAPY EVALUATION AND TREATMENT

I authorize Fleming Physical Therapy Consultant PC, to perform upon _____
(Patient's Name)

Physical Therapy evaluation and treatment as referred by _____
(Physician or Specialist)

I understand the intended purpose of the evaluation and treatment and the potential risks have been explained to me.

Signed:_____ _____
(Patient's Signature) (Witness Signature)

Any patient receiving treatment absent a referral from a physician, dentist, podiatrist, physician assistant or nurse practitioner must be informed that physical therapy may not be covered by the patient's health care plan or insurer without such a referral and that such treatment may be a covered expense if rendered pursuant to a referral.

Signed:_____ _____
(Patient's Signature) (Therapist Signature)

ALLERGIES: List any medications you are allergic to: _____
Are you latex sensitive? YES NO List any other allergies we should know about:
_____

Have you EVER been diagnosed as having any of the following conditions?

YES NO Cancer. If YES, describe what kind_____
YES NO Heart Problems
YES NO High Blood Pressure
YES NO Circulation Problems
YES NO Asthma
YES NO Emphysema/Bronchitis
YES NO Chemical Dependency (i.e., alcoholism)
YES NO Stroke
YES NO Thyroid Problems
Yes NO Diabetes
YES NO Epilepsy
YES NO Headaches
YES NO Multiple Sclerosis
YES NO Rheumatoid Arthritis
YES NO Other Arthritic Conditions
YES NO Depression
YES NO Hepatitis
YES NO Tuberculosis
YES NO Kidney Disease
YES NO Other_____

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:
1._____Date:_____ 2. _____Date:_____

Please describe any significant injuries for which you have been treated (including fractures, sprains) and the approximate date of injury:
1. _____ Date:_____2. _____ Date:_____

Have you had previous treatment for the condition or similar condition for which we are seeing you today:
YES NO If YES: WHEN and WHAT were the treatments:_____
_____

Please list any PRESCRIPTIONS or OVER-THE-COUNTER medications you are currently taking (including pills, injections, skin patches). If you have a list with you, ask your therapist to make a copy.
1._____ 2._____ 3._____
4._____ 5._____ 6._____

Have you recently noted any of the following:
YES NO Weight Loss/Gain
YES NO Weakness
YES NO Nausea/Vomiting
YES NO Fever/Chills/Sweats
YES NO Fatigue
YES NO Numbness or Tingling

_____ _____
Therapist Signature Date