Staten Island Physical Therapy, PC

Hands You Can Trust

NEW PATIENT INTAKE FORM

Patient Name: ____ DOB:___/____/____ SS:_____-______-_______

Last   First   MI

Address: ____City______________State_________Zip__________

Home Phone (_____) ________________ Work (_____) _______________ Cell (_____) ____________________

Circle One Sex M F Marital Status: Married/Single/Other Referring Physician: _____________________

Is your condition related to (circle one): Employment: Y N Auto Accident: Y N

Injury Date: ____________________ Surgery Date: _______________

How did you hear about Staten Island Physical Therapy? (Check One):

Billboard___Church Bulletin___Phone Book___JCC/MCA___Newspaper____Other____________________

Have you or are you currently receiving treatment for this or any other injury (including therapy/ chiropractic care at another office: Y N

INSURANCE INFORMATION

Name of Coverage: ___________________________ Insured's Name __________________________________

Address of Insurance Co: ________________________ City:_________________ State:_______Zip:_________

Relationship to insured (Circle one): SELF SPOUSE CHILD OTHER

Insured DOB: _____/_____/______ Insured's SS#:_______-______-_________

Insured's Address (If different from one above):____

Policy/ID#:____ Group #:__________________________________

Secondary Insurance:________________________________ Name of Insured Party______________________

Address of Insurance Co:__________________________City:___________State:_________Zip:_____________

Policy/ID#:__________________________________Group#:____

EMPLOYMENT INFORMATION

Employment Status: Full Time Part Time Unemployed Other:______________________

Insured's Employer Name: ____

Insured's Employer Address: ____________________________City:__________State:______Zip:___________

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BASIC MEDICAL HISTORY

1. Please inform us of any medical condition we should be aware of (i.e: pace maker, heart condition, diabetes, etc): ____

____

2. Do you have any allergies we should be aware of? If yes, please list:

____

____

3. Are you currently taking any medications? If yes, please list:

____

____

4. Are you pregnant or think you may be pregnant? Y N

5. Have you received treatment in any other physical therapy facility within the past 12 months? If yes, please list: ____

____

WORKER'S COMPENSATION/NO FAULT INFORMATION

Carrier Case/Claim Number: ____________________ Policy Number: ____________________

Insurance Carrier: ____

Insurance Address: ____________________ City: __________ State: _____ ZIP: ________

Phone: (____) ______________ Claims Representative handling your claim ____________________

Are you currently working with a case manager?: Y N If Yes, Name: ____________________

Are you currently unable to work? Y N If yes, as of what date? ____________________

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PATIENT INSURANCE AUTHORIZATION

Patient Name: ____**Policy #:**_______________________________

I request that payment of authorized insurance benefits be made on my behalf to:

Staten Island Physical Therapy, PC for any service provided to me by that physician/therapist/supplier. I authorize any holder of medical information about me to release to ***Staten Island Physical Therapy, PC*** and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. "If other health insurance" is indicated in term 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned case, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for deductible, coinsurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

____ _____________________________________

Patients Signature Date

WORKER'S COMPENSATION AGREEMENT

In the event I fail to prosecute the claim for Worker's Compensation for the illness or condition or is determined by the Worker's Compensation Board that the illness or condition is not a result of a compensable Worker's Compensation Case,

I (name) ______________________________________ hereby agree to pay ***Staten Island Physical Therapy, PC*** fees for services rendered to the above named claimant in the identified case.

____ _________________________________

Patient's Signature Date

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PATIENT HIPAA AWARENESS

With my permission, ***Staten Island Physical Therapy, PC*** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to ***Staten Island Physical Therapy's*** Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. ***Staten Island Physical Therapy, PC*** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the privacy officer.

With my permission, the office of ***Staten Island Physical Therapy, PC*** may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of ***Staten Island Physical Therapy, PC*** may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked personal and/or confidential.

With my permission, the office of ***Staten Island Physical Therapy, PC*** may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that ***Staten Island Physical Therapy, PC*** restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing ***Staten Island Physical Therapy, PC*** to use and disclose my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

____

Patient's Name

______________________________ ____________________

Signature of Patient or Legal Guardian Date

____

Print Name of Patient or Legal Guardian