Patient Information

Name______________________________ circle one: male female
Date of Birth____________________ Social Security No________________
Street Address____
City____________________ State ________ Zip ________
Home Phone # ____________________ okay to contact? Y N
Cell Phone # ____________________ okay to contact? Y N
Work Phone # ____________________ okay to contact? Y N
Email ____________________
Would you like to receive email appointment reminders? Y N
Marital Status: married single other

Injury area________________________ Injury Date __________
Surgery Date __________
Have you been treated for this injury before? Y N
Was the injury a result of an auto accident? Y N
Did the injury occur at work? Y N

In Case of Emergency

Contact Name________________________ Relationship ______________
Phone ________________________

Employer Details

Name____________________________ Phone No.____________
Street Address____
City____________________ State ________ Zip ________
Occupation____________________________
Status: employed unemployed full time student part time student

Policy Holder

Name____________________ Phone No. ________________
Date of Birth____________________ Social Security No________________
Relationship to Patient ______________
Street Address____
City____________________ State ________ Zip ________
Employer Name________________________ Phone No.________________

Referring Physician

Name____________________________ Phone No.____________
Street Address____
City____________________ State ________ Zip ________
Referral date____________________ next appointment date____________

Primary Care Physician

Name_______________________ Phone No.______________
Street Address____
City_____________________ State _______ Zip __________

Worker's Comp *(if applicable)*

Did the injury occur while at work? Y N
Have you reported the injury to your employer? Y N
Date of Injury______________
WCB#_____________________

No Fault *(if applicable)*

Is this a No Fault Claim? Y N
Where did the accident occur? _______________________
Date of Accident _______________

Insured's Name_______________________ Phone No.______________
Street Address____
City_____________________ State _______ Zip __________

Insurance
Company Name_________________ Phone No__________________
Street Address____
City_____________________ State _______ Zip __________

Policy # _________________
Claim # _________________

I hereby certify that all information is true and accurate to the best of my knowledge and I am responsible for all charges incurred for these services. I hereby authorize the release of any medical information necessary to process my claim and authorize my insurance company to pay Premier Care Physical Therapy, PLLC directly for services rendered.

Signature___________________________ Date _______________
(rev 10/10)

Authorization for Release of Information By & Assignment of Benefits To

Premier Care Physical Therapy, PLLC

Insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies have fixed allowances for certain procedures and others pay a percentage of the charge. It is the responsibility of the patient/member to pay any deductible amount, co-insurance, or any other balance not paid by insurance. Subject to limitations by law or by third party contracts, the undersigned agrees to be responsible for payment for all services rendered by this facility. The undersigned agrees that the insurance information supplied to the offices of Premier Care Physical Therapy, PLLC is true and correct. Payment shall be made within ten (10) days of receipt of an invoice.

Insurance checks paid directly to the patient/member for services rendered by Premier Care Physical Therapy, PLLC shall be endorsed to Premier Care Physical Therapy, PLLC and presented to this office along with any attached Explanation of Benefits within five (5) business days. In the event these checks are cashed for personal use, the undersigned patient/member will be subject to interest allowed by law, all legal costs as outlined below, and termination of treatment by this facility.

In the event that the provider retains the services of an attorney to enforce its rights, whether or not suit is instituted, the undersigned agrees to be responsible for all legal fees, court costs, expenses, disbursements, and any other collection costs. To the extent permitted by law, the parties agree that jurisdiction and venue shall be in Sullivan County, New York, in a court of appropriate monetary jurisdiction.

In the event that more than one party signs this agreement, each party agrees to be jointly and severally responsible for the full un-reimbursed cost of the services provided as well as the collection fees as set forth herein.

I hereby authorize the release of any information to government agencies, insurance carriers or others who permit representatives thereof to examine and copy all records relating to care and treatment at Premier Care Physical Therapy, PLLC necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my or my dependent's behalf. I assign the benefits payable to which I am entitled, including those from government agencies, insurance carriers and all other entities who are financially liable for my medical care of that of my dependents to cover the cost of such care and treatment rendered to myself or my dependents, to Premier Care Physical Therapy, PLLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

I hereby grant my permission to the authorized representatives of Premier Care Physical Therapy, PLLC to share information as necessary regarding my medical status, care and treatment with the following individuals as well as those accompanying me on my visits to this facility.

______________________________ ______________________________

______________________________ ______________________________

I hereby agree to the releases, assignments and financial responsibilities above

Patient Name: ______________________________

Patient Signature: ______________________________ Date: ____________________
(patient or parent if patient is under the age 18)

(rev 10/10)

Premier Care Physical Therapy

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1) Uses and Disclosures We will use your protected health information (PHI) for the purposes of treatment, payment and health care operations.

Treatment includes the disclosure of health information to other providers who have referred you for services or are involved in your care. This may include doctors, nurses, technicians and other physical therapists. For example, we may feel that a stroke patient we are treating would benefit from an evaluation by a speech-language pathologist to address a swallowing difficulty. The health information we share with the speech-language pathologist would be considered a treatment related disclosure.

Payment includes the disclosure of health information to your insurance company, including Medicare and Medicaid, so payment can be obtained for services rendered. Your insurance company may make a request to review your medical record to determine that your care was necessary.

Health Care Operations includes the utilization of your records to monitor the quality of care being given at our facility or for business planning activities.

Other Special Uses
Our practice may use your PHI to send you an appointment reminder, to inform you of our other health-related products and services, or to request a contribution to our charitable activities.

Uses and Disclosures Required by Law
The federal health information privacy regulations either permit or require us to use or disclose your PHI in the following ways: we may share some of your PHI with a family member or friend involved in your care if you do not object, we may use your PHI in an emergency situation when you may not be able to express yourself, and we may use or disclose your PHI for research purposes if we are provided with very specific assurances that your privacy will be protected. We may also disclose your PHI when we are required to do so by law, for example by court order or subpoena. Disclosures to health oversight agencies are sometimes required by law to report certain diseases or adverse drug reactions.

We may use and disclose health information about you to avert a serious threat to your health or safety or the health or safety of the public or others. If you are in the Armed Forces, we may release health information about you when it is determined to be necessary by the appropriate military command authorities. We may also release information about you for workers' compensation or other similar programs that provide benefits for work-related injury or illness.
Your authorization is required before your PHI may be used or disclosed by us for other purposes.

2) Your Privacy Rights

Restrictions
You have the right to request restrictions on how your PHI is used, however, we are not required to agree with your request. If we do agree, we must abide by your request.

Confidential Communications
You have the right to request confidential communication from us at a location of your choosing. This request must be in writing.

Access to PHI
You have the right to request a copy of your medical record. You must make this request in writing and we may charge a fee to cover the costs of copying and mailing.

Amendments
You have the right to request an amendment be made to your PHI, if you disagree with what it says about you. This request must be made in writing. If we disagree with you, we are not required to make the change. You do have the right to submit a written statement about why you disagree that will become part of your record. We may not amend parts of your medical record that we did not create.

Accounting of Disclosures
After November 1, 2010, you have the right to request an accounting of the disclosures made in the previous six years. These disclosures will not include those made for treatment, payment, or health care operations or for which we have obtained authorization.

Complaints
If you feel that your privacy rights have been violated, you have the right to make a complaint to us in writing without fear of retaliation. Your complaint should contain enough specific information so that we may adequately investigate and respond to your concerns. If you are not satisfied with our response, you may complain directly to the Secretary of Health and Human Services.

Our Duty to Protect Your Privacy
We are required to comply with the federal health information privacy regulations by maintaining the privacy of your PHI. These rules require us to provide you with this document, our Notice of Privacy Practices. We reserve the right to update this notice if required by law. If we do update this notice at any time in the future, you will receive a revised notice when you next seek treatment from us.

Privacy Contact
If you would like more information about our privacy practices or to file a complaint you may contact:

Premier Care Physical Therapy
Attn: Privacy Officer
55 Sturgis Road, Suite 2
Monticello, NY 12701
Phone: 845-707-4371

Patient Name: ______________________________

Patient Signature: ______________________________
(patient or parent if patient is under the age of 18)

Date: ________________

This Notice will take effect on November 1, 2010.

(Rev 10/10)

Premier Care Physical Therapy

Authorization for Medical Treatment

In the event emergency medical treatment is required due to illness or injury during the process of receiving services or while being on the property of this facility, I authorize Premier Care Physical Therapy, PLLC to:

- Secure and retain medical treatment and transportation if needed
- Release any records upon request to the authorized individual or agency involved in the medical emergency treatment

Patient Name: ______________________________

Signature: ______________________________ Date: ______________________________
(patient or parent if patient is under the age 18)

(Rev 10/10)

Premier Care Physical Therapy

Financial Policy

Payment is due at the time services are rendered. This includes, but is not limited to, co-insurance, co-payments and deductibles. If a check is returned for insufficient funds, you will be charged all applicable bank fees in addition to the amount of the check.

After the insurance company has paid their portion of your claim, should your financial responsibility remain unpaid after ninety (90) days, the account will be turned over to a collection agency unless other financial arrangements have been made. You will be responsible for any collection costs in addition to the unpaid balance.

I understand and agree to comply with the policy explained above.

Patient Name: ______________________________

Patient Signature: ______________________________ Date: ________________
(patient or parent if patient is under the age 18)

(Rev 10/10)

55 Sturgis Road, Suite 2, Monticello, NY 12701 | P: 845-707-4371 | F: 845-796-0197