PATIENT FACE SHEET

INFO TAKEN BY: _____

Date Of Call	Patient Account #	How Did You Find Out About Us ?	Last Md Visit	Physical Therapist
Patient Last Name:		First Name:		Middle
Phone #s and Email Address : (H) (W) (C) Email :				
Emergency Contact : Ph #s: DOB : Gender : Marital Status :			Job Desc : Op Report :	
SSN :		Employer :		
Current Rx Signed on :		Receiving Skilled Nursing ? :		Previous Physical Therapy :
Mailing Address :				
Treatment Address :				
Facility :		Additional Info :		

Referring MD :	MD to receive notes ?	PCP MD :	MD to receive notes ?
Frequency:			
RX : **ICD - 9 Diagnosis :** DOI : DOS :			

Primary Insurance :			Subscriber # :		
Adjuster :		Address :		Phone #s :	
Injured Person :			DOB :	Relation :	
Date :	S/W :	Coverage :	Deductible :	Start / End Date :	# of Visits :

Secondary Insurance :			Subscriber # :		
Adjuster :		Address :		Phone #s :	
Injured Person :			DOB :	Relation :	
Date :	S/W :	Coverage :	Deductible :	Start / End Date :	# of Visits :

I _____ **have reviewed and attest to the accuracy of the information .**

SIGNATURE: _____ DATE: _____

WSPT

PHYSICAL THERAPY

AQUATIC THERAPY • WELLNESS

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PATIENT INFORMATION

NAME: _____ OCCUPATION: _____ AGE: _____

Date of Onset: Injury/problem/surgery: _____ Height: _____ Weight: _____

Briefly state previous treatment, if any: _____

_____

Do you have now, or have you ever had, any of the following?

	YES	NO		YES	NO
DIABETES			**ALLERGY TO COLD**		
HIGH BLOOD PRESSURE			**OTHER ALLERGIES**		
PACEMAKER			**PREVIOUS SURGERIES**		
CHRONIC HEADACHES			**CIRCULATORY DISEASE**		
KIDNEY PROBLEMS			**METAL IMPLANTS**		
SEIZURES			**DIZZINESS**		
HERNIA			**CANCER**		
ALLERGY TO HEAT			**PREGNANT**		
BONE DISEASE			**OSTEOPOROSIS**		
BLADDER PROBLEMS			**FRACTURES**		
BOWEL PROBLEMS			**RECENT WEIGHT LOSS**		
PINS AND NEEDLES			**NERVOUS DISORDER**		
PROBLEMS WITH BOTH ARMS OR BOTH LEGS AT THE SAME TIME					

If YES to any of the above, please explain and give appropriate details: _____

_____

_____

Are you presently taking any medications? YES NO If YES, please list your medications and for what conditions:

_____

_____

Have you had any x-rays, CAT scene, MRI's, or other diagnostic tests for your recent order? YES NO
If YES, please explain the findings as you understand them:

_____

_____

Is there anything else you think we should know about your general health, or current condition? Please explain and if, necessary, we can talk about it:

_____

PHYSICAL THERAPIST SIGNATURE: _____ DATE: _____

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PATIENT FINANCIAL RESPONSIBILITY

Realizing that financial surprises can be unpleasant, we wish to provide you with the following information concerning your financial responsibility for the services that you receive from WSPT.

If your insurance policy requires a referral from your Primary Care Physician (PCP), it is your responsibility to obtain that referral. We are happy to assist you in obtaining referrals, however, the responsibility is ultimately yours.

Payment is requested at the time of service for any amounts which will be applied to copay, deductible or coinsurance. In addition, some services or supplies may not be covered by your insurance. Payment for these items will be requested at the time of service.

Please inform us of any insurance changes. Failure to provide current insurance information may result in a denial of claims which could then become your responsibility. Please keep in mind that many insurance carriers have a claim filing deadline, sometimes as short as 60 days.

Cancellations must be made more than 24 hrs in advance of scheduled appointment. A charge of $25 will be incurred for late notice (less than 24hrs) and/or same-day cancellations. If you no-show three appointments in one month you may be discharged and forfeit future appointments. Please note there is an answering machine during after business hours for your convenience.

NAME OF BENEFICIARY (PATIENT): _____

HIC OR ID NUMBER: _____

I request that payment of authorized Medicare or other insurance benefits be made on my behalf to WSPT for any services furnished me by WSPT. I authorize any holder of medical information about me to release to my insurance carrier or to the Centers for Medicare Services (CMS) or its agents any information needed to determine these benefits or the benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, 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 the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier. For all managed care plans (HMO, PPO, POS, EPO or other), I understand that I will be responsible for the copay, deductible and coinsurance as governed by the managed care contract, as well as for any services deemed non-covered.

BENEFICIARY (PATIENT) SIGNATURE: _____

DATE: _____

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PRIVACY DISCLAIMER

In providing services to you, we create and store health information that identifies you. We understand that this information about you and your health is personal, and we are committed to protecting the privacy of this information. We must obtain your one-time consent before services are rendered.

REVOKING CONSENT

You have the right to revoke this consent at any time, except to the extent that the office has already taken action based upon your consent. For example, if you revoke your consent after the office has provided treatment, the office is permitted to use or disclose your health information to bill for that treatment. To revoke this consent, please send a written request to our office.

SCOPE OF CONSENT

By signing this form, I hereby consent that my information is correct and authorize Westchester Square Physical Therapy (WSPT), PC and its providers to use and disclose my personal health information, as necessary, for the purposes of obtaining medical treatment, facilitating payment of services rendered, and for normal business.

USE OF IMAGES

For valuable consideration received, I hereby grant to Westchester Square Physical Therapy and his/her legal representatives and assigns, the irrevocable and unrestricted right to use and publish photographs and footage of me, or in which I may be included, for editorial, same without restriction: and to copyright the same. I hereby release Photographer and his/her legal representatives and assigns from all claims and liability relating to said photographs.

VIDEO SURVEILLANCE

WSPT believes that safeguarding the personal welfare of its patients and employees is of paramount importance. In an effort to discourage those behaviors which threaten personal safety or a potential loss, selective use of video surveillance is engaged at our office. Areas under surveillance include, but are not limited to, waiting room, gym floor, and corridors. WSPT respects the privacy of its patients and employees and works diligently to balance that privacy against safety needs

PATIENT OR REPRESENTATIVE SIGNATURE: _____

DATE: _____

WSPT

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NO FAULT BENEFIT OF ASSIGNMENT FORM

I, _____ , (Assignor) hereby assign to _____ , (Assignee
(PRINT PATIENT'S NAME) (PRINT HOSPITAL OR HEALTH CARE PROVIDER NAME)
all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the NO-FAULT statute) of the insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____ notwithstanding any other agreement to the contrary.
(PRINT ACCIDENT DATE)

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

_____ _____
PRINT NAME OF PATIENT SIGNATURE OF PATIENT

_____ _____
DATE OF SIGNATURE

_____
ADDRESS

_____ _____
PRINT NAME OF PROVIDER SIGNATURE OF PROVIDER

_____ _____
DATE OF SIGNATURE

_____
ADDRESS