Western New York Physical & Occupational Therapy Group, PLLC

NEW PATIENT INFORMATION SHEET

Allergies ____________________

Name____________________ Home Phone ____________ E-mail address____________

Address ____________________ City ____________ State ______ Zip ______

Date of Birth ____________ Social Security Number ____________ Marital Status____________

Place of Employment ____________ Occupation____________ Work Phone ____________

In case of emergency contact____________________ Phone Number____________

Address ____________________ Relationship ____________

Second emergency contact ____________ Phone Number ____________ Relationship ____________

Referring Physician ____________________ Family Physician ____________________

☐ *GENERAL INSURANCE INFORMATION*

Primary Insurance ____________________ Secondary Insurance ____________________

Subscriber's Name ____________________ Subscriber's Name ____________________

Subscriber's Date of Birth ____________________ Subscriber's Date of Birth ____________________

Certificate or ID# ____________________ Certificate or ID# ____________________

Group or Access # ____________________ Group or Access # ____________________

Authorization # (*When Applicable*) ____________ Authorization # (*When applicable*) ____________

☐ *NO-FAULT INSURANCE INFORMATION*

Insurance Company Name ____________________ Phone Number ____________

Address ____________________ City ____________State ______ Zip ______

Policy #____________ Claim/File # ____________ Date of Injury ____________

Insured's Name ____________________ Was a motorcycle or DWI involved? _____ Yes _____ No

☐ *WORKERS' COMPENSATION INSURANCE INFORMATION*

Employer ____________________ Work phone ____________

Address ____________________ City ____________ State ______ Zip ______

Insurance Carrier Name ____________________ Phone number ____________

Address ____________________ City ____________ State ______ Zip ______

WCB# ____________ Carrier Case # ____________ Date of Injury ____________

Insurance Adjuster ____________________ Are you working now ? _____ Yes ______ No

Address where injury occurred ____________________

I hereby certify that the information above is, to the best of my knowledge, complete and accurate. I understand that I am financially responsible to Western New York Physical & Occupational Therapy Group, PLLC for all therapy services rendered at this clinic whether or not covered by insurance. I also hereby authorize release of information pertaining to my medical condition and therapy treatment to my insurance company, Social Security Administration or Medicare program.

SIGNATURE ____________________

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STATEMENT TO AUTHORIZE PAYMENT OF BENEFITS

I certify that the information given by me in applying for payment is correct. I authorize WNY Physical & Occupational Therapy Group, PLLC to release any medical information required to process my claim. I request that payment be made to WNY Physical & Occupational Therapy Group, PLLC for services provided to me.

SIGNATURE____________________ DATE ____________

(revised 10/08)

WESTERN NEW YORK PHYSICAL & OCCUPATIONAL THERAPY GROUP, PLLC

PATIENT HISTORY AND TREATMENT CONSENT

Name:____

Occupation:____________________________________Are you working now?__________

Describe your job:____

Describe your injury or symptoms:____

How did your injury occur? ____
(Continue on reverse if more room is needed)

What are your goals/expectation of your therapy treatment: _____________________________

Have you ever received Physical Therapy for this condition/injury?________________________
Are you presently being treated by a chiropractor?________ Have you had: X-rays/MRI/CAT Scan (circle)
Have you had any of the following? (Please check)

_____ Diabetes (IDDM or NIDDM)
_____ Rheumatic Fever
_____ Cancer
_____ Stroke
_____ Broken Bones (fracture)
_____ Kidney disease
_____ Metal Implants

____Migraine Headaches
____Varicose veins
____Circulatory problems
____Hypertension
____Heart Disease
____Osteoporosis
____Liver Disease

____Neurological problems (numbness, weakness, tremors, seizures)
____Heart murmur (please explain)________________
____Lung Disease
____Epilepsy/seizures
____Arthritis
____Allergies_____________________________
____Current Infection _________________________
Other__________________________________

List any medications you are presently taking: ____

____

List any surgeries you have had:____

Do you smoke?_____ Have a pacemaker? _____ Exercise regularly?______ Chest discomfort?_____

Females: Is there a chance you may be pregnant at this time?_________________

What was your primary reason for choosing our facility for physical therapy? Please X choice.

	Primary Physician Recommendation		Specialist Physician Recommendation		Insurance Co./Directory		Rehab Nurse Recommendation
	Radio Ad		Newspaper or Magazine Ad		Friend/Family		Verizon Telephone Book
	Contact with staff member		Coach		Website		Talking Phone Book
	Previously treated here		Convenient location		Other		Television Commercial

I authorize WNY Physical & Occupational Therapy Group, PLLC, to render Physical and/or Occupational therapy care pursuant to a referral from a licensed physician, dentist, podiatrist, physician's assistant or nurse practitioner in accordance with Federal and NY State Law. I understand that I have the right to consent to; or refuse to consent to; any proposed therapy procedure after receiving information about the benefits and possible associated risks.

____________________________ ____________________________ ____________
Patient Signature/Legal Guardian Therapist Signature Date

Updated: March 31, 2010

Western New York Physical & Occupational Therapy Group, PLLC

Consent for Disclosure of PHI

I understand that as part of my treatment, payment for my treatment, and health care operations (TPO), it may be necessary to disclose my Protected Health Information (PHI) to another entity. I consent to such disclosure for these purposes via telephone, dedicated/secured fax or safeguarded e-mail.

Yes	No	
□	□	You may contact me by phone at home.
□	□	You may contact me by phone at work.
□	□	You may leave messages on my answering machine/voice mail or ___anyone in my household ___only with (give names)____

In addition to the standard (TPO) disclosures listed above, you may also disclose my Private Health/Billing information to the following person/persons in order for them to assist me in my care:____.

___*I have received the Notice of Privacy Practices from WNY Physical & Occupational Therapy Group PLLC

___ I refuse to accept the Notice of Privacy Practices

Patient Name:____

Patient Signature/Representative:_________________________________ Date:________________

Relationship to patient:____

For office use only

____ Patient refused to read/sign
____ Patient is unable to sign
____ Patient is unable to read. The staff read the information to the patient.

Staff Signature:____

If you have any questions about the HIPAA Privacy Rules, please contact Privacy Officer, at 716-684-0400.

11/23/04

Western New York Physical & Occupational Therapy Group, PLLC

General Insurance/Financial Information

Welcome to **Western New York Physical & Occupational Therapy Group, PLLC**. We thank you and your physician for choosing our practice for your rehabilitation services.

Your insurance plan requires a written order (prescription) from a NYS licensed medical doctor, osteopathic doctor, physician assistant, nurse practitioner, podiatrist or dentist in order for treatment to be rendered. The prescription is valid from the date of your initial visit for the time period specified by your physician. If there is no time period specified on your script, it is only valid for 30 days from the date written. It is the patient's responsibility to obtain a new prescription each time the previous prescription expires.

WNY PT & OT is pleased to offer our patients the courtesy of participating with most major insurance plans:

AETNA (MagnaCare Network)
BCBS OF WNY
COMMUNITY BLUE
FIDELIS CARE
GHI
INDEPENDENT HEALTH
MEDICARE PART B (separate handout)
NORTH AMERICAN PREFERRED/BEECHSTREET
NOVA
NYS EMPIRE PLAN
POMCO (limited providers)
PRISM HEALTH NETWORKS
RAILROAD MEDICARE (separate handout)
SENECA NATION OF INDIANS
TRICARE/CHAMPUS
UNITED HEALTHCARE
UNIVERA

Benefit quotes are not a guarantee of payment as they are subject to plan provisions and based upon information currently available.

☐ **ACCEPT INSURANCE:** If you have one of the above insurance plans, we agree to bill your plan directly and accept assignment as directed by the plan. If your plan requires a referral or preauthorization for physical or occupational therapy services, it may be your responsibility to have the referral/preauthorization in place by your initial visit.

☐ **PRIVATE INSURANCE:** ____ WNY PT & OT Group is **non-participating** with your health plan and is not subject to any plan provisions. As a courtesy to you, we will bill your health plan directly if you have all the necessary information with you today. The fee for your treatment is based on the services rendered and may vary with each visit. If payment is not received from your insurance plan within 60 days from our billing date, we may require payment from you.
Liability cases (personal injury not on your property) are billed to the insurance carrier only if there is written authorization of payment on file at the time of your initial visit.

FINANCIAL RESPONSIBLITY: Your insurance plan, a contract between you and the carrier, requires that copays/coinsurance be made. **The copay/coinsurance amounts are due at the time of service.** Additional financial responsibilities may include deductible and "non-covered services" based on your health plan's provisions. Cash, check, credit card payments are accepted.

Any questions regarding your account can be directed to our Billing Department by calling 684-0400 Monday through Friday 8:00 am to 5:00 pm. Our patient account representatives will be happy to answer your questions and address your concerns.

Your signature below certifies that you have read and understand the information provided regarding your insurance plan and financial responsibility as they pertain to PT/OT.

SIGNATURE ____ DATE _____/_____/_____
(Patient or Responsible Party)