Print email

PATIENT CONTACT INFORMATION:

EMAIL: _____

First Name: _____ Last Name: _____ MI: _____

Age: _____ DOB: _____ Social Security #: _____

Street: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

If Patient is a Minor; Parent Guardian Name: _____ Contact #:_____

In the event we need to contact you, which number would you like us to call? CELL_____ HOME_____WORK_____

Student Status: _____ Who may we thank you for referring you to our office? _____

EMERGENCY INFORMATION:

In case of an emergency who should be notified? _____ Phone #:_____

Relationship to patient_____ Additional #'s:_____

Name of Physician referring you for Physical Therapy: _____

Have you received care from another Healthcare Professional for this injury? ☐YES / ☐NO Please list name/phone:

_____

Where is your problem? (Please circle all that apply for this visit) **Which Side?** ☐Right / ☐Left / ☐Both

☐Ankle ☐Knee ☐Hip ☐Elbow ☐Wrist ☐Neck ☐Upper Back ☐Lower Back ☐Other: _____

Did you have surgery for this condition? ☐Y/☐N YES when? _____**Type of Surgery?** _____

Which is your Dominant Arm? ☐Left/☐Right **Height:** _____**Weight:** _____

Do you smoke? ☐YES ☐NO If yes, how much? _____ **Do you receive Home Healthcare Services?** ☐YES ☐NO

Have you had prior Hospitalization? (Please explain)_____

Do you have a history of falls? ☐No ☐ Yes_____

Functional Limitations: (Please circle all that apply) ☐Sleep ☐Self Care ☐ADL's (Activities of Daily Living)

☐Reaching/Pulling/Pushing ☐ Lifting/Carrying ☐Sitting/Standing ☐Bending/Squatting ☐Mobility/Ambulation

Please indicate nature of your symptoms (Please circle only one) ☐Burning/Sharp ☐Dull/Ache ☐Throbbing/Shooting ☐Numbness/Tingling

How did you injure yourself? _____

☐ No injury, just started hurting ☐ Sports:_____ ☐ Motor Vehicle Accident

☐ Fall ☐ Work/Job Is there a Workers Comp Claim? ☐YES/☐NO

How long have you had symptoms? _____ **Date of Injury**: _____

Briefly describe your injury: _____

Are you currently working? ☐Y /☐ N **Name of Occupation**: _____ **Status:** ☐F/T ☐P/T

☐Light Duty ☐Transitional ☐Out of Work ☐Retired ☐ Not Working ☐ Homemaker ☐Out of work since: _____

Pervious treatments for this injury (medications, injections, bracing, surgery, Chiropractic, pain management):

_____

X-Rays ☐YES/☐NO Date: _____ **MRI** ☐YES/☐NO Date: _____

CT Scan ☐YES☐/NO Date: _____ **Doppler** ☐YES/☐NO Date: _____

Patient Initial Intake Form

Patient Name: _____ **Date:** _____

How severe is the pain (0=none, 10=severe pain):

At Best? 0 1 2 3 4 5 6 7 8 9 10 0

Currently? 0 1 2 3 4 5 6 7 8 9 10 0

At Worst? 0 1 2 3 4 5 6 7 8 9 10 0

Is the pain getting: ☐**Better** ☐**Worse** ☐**Same**

What makes your problem better? _____

What makes your problem worse? _____

Have you had similar symptoms in the past? ☐YES☐/NO **If yes**, Date and Treatments you received: _____

Pervious Surgeries (include dates): _____

Activity Level: ☐ Sedentary ☐ Light Activity ☐ Moderate ☐ Very Active ☐ Extremely Active

In general would you say your health right now is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Are you currently pregnant, or trying to become pregnant? ☐YES /☐ NO

Do you have Latex Allergies? ☐YES /☐ NO

Do you have any Allergies? _____

Medical History: (please check all that apply)

Pacemaker	☐	Shortness of Breath	☐
Cardiovascular Disease	☐	Swelling in Legs	☐
High Blood Pressure	☐	Swelling in Joints	☐
Cancer	☐	Headaches	☐
Ear Infection	☐	Dizziness	☐
Hearing Loss	☐	Numbness/loss of sensation	☐
Chest Pain	☐	Depression	☐
Weakness/Fatigue	☐	Anxiety	☐
Recent Vision Change	☐	Osteoarthritis	☐
Diabetes Type_____	☐	Other health problems please explain:	

Please list your medications, dose and frequency (please include any vitamins or over the counter medications):

Medication Name: _____ Dosage: _____ Frequency: _____

Medication Name: _____ Dosage: _____ Frequency: _____

Medication Name: _____ Dosage: _____ Frequency: _____

_____ _____

Patient Signature **Date**

Therapist Signature & Date: _____

ASSIGNMENT OF BENEFITS

As a medical provider, our relationship is with you, not your insurance company. As a courtesy to our patients, we are willing to submit your claims to your insurance company for reimbursement, providing your insurance company allows us to do so. However, all charges are ultimately your responsibility from the first date services are rendered. To this regard, you are responsible for your co-payments, deductible and any portion of our claims your insurance company chooses to exclude from payment. If you have any questions regarding the above or any uncertainty regarding your insurance coverage, please do not hesitate to ask us. We are here to assist you.

PRIMARY INSURANCE INFORMATION

PATIENTS NAME: _____

PRIMARY INSURANCE CARRIER: _____

PRIMARY INSURANCE POLICY/ID#:_____

INSURANCE CARRIER PHONE #:_____

NAME OF INSURED: _____RELATIONSHIP TO INSURED: _____

ASSIGNMENT OF BENEFITS

Provider: William J. Schwarz, P.T., P.C.

5700 Merrick Road

Massapequa, NY 11758

In consideration of services rendered, I hereby assign to the provider and or his/her assignees so much of my first party insurance benefits and rights shall equal the full amount of the bill for such services and the provider and his/her assignees may secure in my name. If the above provider is an in-network provider of my primary insurance then my financial liability is limited to that which these insurance companies are required to pay (i.e. co-payments, deductibles coinsurance, etc). Also by signing this form I understand that I authorize this office to release all information regarding my condition for payment purposes of my claims if my insurance company requires such. This authorization will be void, once all claims are paid in full.

X _____

Signature of Patient (if patient is minor parent/guardian must sign) Date

I HEREBY STATE THAT THE INJURY WHICH I AM RECEIVING TREATMENT FOR IS NOT DUE TO A WORKMAN's COMPENSATION CASE OR NO FAULT ACCIDENT.

X_____

Signature of Patient **Date**

IT IS THE PATIENTS RESPONSIBILITY TO INFORM US IF YOUR INSURANCE CARRIER CHANGES DURING YOUR TREATMENT HERE. IF YOU FAIL TO INFORM US YOU WILL BE HELD RESPONSIBLE FOR ALL CHARGES NOT COVERED.

X_____

Signature of Patient (if patient is a minor parent/guardian must sign) **Date**

PRIVACY POLICY

As a healthcare provider our office is required by HHS (Department of Health and Human Services) and HIPAA to adopt a privacy policy for our office effective April 14, 2003. We are legally bound to enforce this policy as healthcare providers. This policy is to protect our patient's right to confidentiality. HIPAA and the Administrative Simplification Requirement allows for "incidental disclosure" including but is not limited to treatment in our general treatment area as well as healthcare providers sharing information needed to treat a patient, all to be done with reasonable safeguards. Our employees have been counseled and trained in regards to the confidentiality of a patient's medical record.

I. Penalties

Any employee found violating this policy will be reprimanded up to and/or including termination of employment. Violation of a patient's privacy if found guilty will be subject to civil liability and/or criminal penalties. We are required to report any employee found violating this policy to the Department of Civil Rights. Penalties are as follows: Civil Federal criminal penalties are $100 per violation, up to $25,000 per person per year each requirement of prohibition violated. Federal criminal penalties are up to $50,000 and one year in prison for obtaining protected health information; up to $100,000 and up to five years in prison for obtaining or disclosing protected health information under "false pretenses"; and up to $250,000 and up to 10 years in prison for obtaining or disclosing protected health information with intent to sell, transfer or use it for commercial advantage, personal gain and malicious harm.

II. Patient Charts

Staff members such as PT Aides, front desk staff and Therapists all have access to patient charts for the following reasons; to treat the patient, to set up for a patients treatment plan, request authorization, as well as follow up on claims for payment due at our office, filling out paperwork; maintaining & securing records and communication with the insurance companies and governmental agencies. This will be done in a discrete manner with as little incidental disclosure as possible. A patient or their qualified representative has the right to inspect their patient information within 30 days of our office receiving a written request with the patient's original signature or qualified representative's original signature. Copies of the patients chart maybe furnished to the patient at a charge of $75/per page. A patient's chart may not be copied or reviewed by third party without written authorization from the patient or a qualified representative. This request may be written within 30 days of the patient's/representative's dated signature. Copies will not be released with a Photostat copy of the patient's/representative's signature unless the authorization states otherwise. A patient or their qualified representative may challenge the accuracy of their information and may require their own brief statement be inserted as a permanent part of their patient information and released whenever the information is released. This individual's right only pertains to factual statements and not to a provider's observations, inferences or conclusions. You have the right to receive an accounting of disclosures of protected health information. Patients have the right to make restriction or transfers of their protected health information at any time.

III. Insurance Companies

A patients progress notes will only be released to an insurance company when it is necessary to prove medical necessity for additional visits and or payment of claims. When this information is released to such companies only the necessary information will be released. Information that does not support the medical necessity for continued treatment will not be released. This will be determined by the treating providers own discretion. No Fault cases require copies of patient's progress notes with each claim. When this information is released to such companies only the necessary information will be released. (Workman's Compensation cases are excluded from the HIPAA privacy policies.)

Our patients have the right to feel confident that our office will keep their healthcare information confidential. There will be periodical updates to this policy, as the law requires as well as this office deems necessary. We reserve the right to revise this policy at any time. You also have the right to request a copy of this notice at any time. Questions that a patient has about our privacy policy may be directed to the privacy officer. For more information about the HIPPA or to file a complaint you may contact:

The US Department of Health & Human Services

Office of Civil Rights

200 Independence Avenue

Washington, D.C. 20201

Privacy Officer

William J. Schwarz, P.T., P.C.

5700 Merrick Road

Massapequa, NY 11758

_____ _____ _____

Patient Name Signature Date

William J. Schwarz, P.T., P.C.

PHYSICAL THERAPY

ABOUT YOUR MEDICARE BENEFITS

The following are some facts you should be aware of regarding your Medicare Benefits for Physical Therapy:

1. This office is a participating provider of Medicare.
2. Medicare requires their beneficiaries to satisfy a 147.00 yearly deductible before they will begin paying
3. After your deductible is satisfied, Medicare will reimburse 80% of what they consider to be an "approved fee" providing they do not exceed the charges. An exclusion is a charge that is not covered by your Medical plan. Medicare states that in this case, the patient is responsible for the actual charge billed by the provider.
4. Effective 1/1/06 there is a Monetary Cap on Physical Therapy benefits combined with Speech Therapy benefits as well. The maximum dollar amount Medicare will allow is $1920.00 of which they will pay 80% – ($1398.00) and the member will be responsible for the remaining 20% – ($342.00).
5. On assigned claims the beneficiary, who is the patient, is responsible for the co-insurance (%20 of the approved charge) the deductible per calendar year and any exclusion.
6. To continue Physical Therapy past 30 days, Medicare requires that you return to your Primary Care Physician/Referring Physician within 30 days of your last dated prescription. To determine medical necessity for continued care. WE WILL NEED AN UPDATED PRESCRIPTION EVERY 30 DAYS FROM THE PREVIOUS ONE TO ENSURE MEDICAL NECESSITY. THIS IS THE PATIENTS RESPONSIBILITY.
7. If you are receiving any HOME CARE SERVICES from an agency Medicare will not cover any services at our facility. Medicare stipulates that any patient who is receiving home care services (i.e. Home Health Aide, visiting nurse, etc) must receive all services through that agency. Please inform the front desk staff if you are currently receiving or plan to receive and HOME CARE SERVICES. Any claims denied for this reason will be your responsibility as you have been informed prior to treatment that this is not allowed by Medicare.

If you have any additional questions about your Medicare benefits, please ask one of our front office staff members or your Medicare Representative.

I have read the above regarding my Medicare benefits and understand my responsibility as the beneficiary/patient.

Signature of Patient/Beneficiary Date

MEDICARE ASSIGNMENT FORM

ASSIGNMENT OF BENEFITS:

Name of Beneficiary: _____ Medicare I.D. #:_____

I request that payment of authorized Medicare benefits be made on my behalf to WILLIAM J. SCHWARZ, P.T., P.C. for any services furnished me by the said provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

X_____

Patient's Signature/Date Provider Signature/Date

SECONDARY INSURANCE INFORMATION:

Insurance Company: _____ Group/Plan #: _____

Insured's Name: _____ Social Security #: _____

MEDICARE REGUALTIONS

To continue Physical Therapy beyond 30 days, Medicare now requires that you return to your doctor within 30 days of your last dated prescription to determine medical necessity for treatment. Medicare may deny benefits for Physical Therapy if found without documented cause from your doctor. Therefore you are advised to return to your doctor within each 30-day period of Physical Therapy treatments.

****If you are receiving any HOME CARE services from an agency (i.e. Home Health Aide, visiting nurse, etc) Medicare will not cover services at our facility. Medicare stipulates that any patient who is receiving such services must receive any HOME CARE services. Any claims denied for this reason will be your responsibility as you have been informed prior to treatment that this is not allowed by Medicare.

If you have any questions please do not hesitate to ask any of our office staff or contact your Medicare representative.

I have read the information above regarding my Medicare benefits and understand what my responsibility is as the beneficiary/patient.

X_____

Patient's Signature Date

I also authorize this office to release any reports/findings to my referring physician.

X_____

Patient's Signature Date

I HEREBY STATE THAT THE INJURY WHICH I AM RECEIVING TREAMENT FOR IS NOT DUE TO A NO FAULT OR WORKMAN'S COMPENSATION CASE.

X_____

Patient's Signature Date

OUR OFFICE IS HIPPA COMPLIANT. ANY QUESTIONS REGARDING OUR POLICIES PLEASE ASK THE FRONT DESK STAFF.

*Assignment & Provider Notice Adopted from Medicare Approved Provider Information

Pain Disability Index

Pain Disability Index. The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category indicating the overall impact of pain in your life, not just when pain is at its worst.

For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

Family/Home Responsibilities: This category refers to activities of the home or family. It includes chores or duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g. driving the children to school).
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7__. 8__. 9__. 10__. Worst Disability

Recreation: This disability includes hobbies, sports, and other similar leisure time activities.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7__. 8__. 9__. 10__. Worst Disability

Social Activity: This category refers to activities which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7__. 8__. 9__. 10__. Worst Disability

Occupation: This category refers to activities that are a part of or directly related to one's job. This includes non-paying jobs as well, such as that of a housewife or volunteer.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7__. 8__. 9__. 10__. Worst Disability

Sexual Behavior: This category refers to the frequency and quality of one's sex life.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7__. 8__. 9__. 10__. Worst Disability

Self Care: This category includes activities, which involve personal maintenance and independent daily living.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7__. 8__. 9__. 10__. Worst Disability

Life-Support Activities: This category refers to basic life supporting behaviors such as eating, sleeping and breathing.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7__. 8__. 9__. 10__. Worst Disability

Signature_____ Please Print_____

Date_____