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

Previous 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:

Previous 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: _____

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 out 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 on 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

NO FAULT ASSIGNMENT OF BENEFITS FORM

NYS NO-FAULT LAW: YOU CANNOT BE TREATED BY A PHYSICAL THERAPIST AND A CHIROPRACTOR ON THE SAME DAY FOR YOUR NO-FAULT INURY

PROVIDER: William J. Schwarz, P.T., P.C. **(ASSIGNEE)**

5700 Merrick Road

Massapequa, NY 11758

SIGNATURE OF ASSIGNEE: _____

NAME OF PATIENT: _____ DOA: _____
(ASSIGNOR) (Date of Accident)

I hereby assign to William J. Schwarz, P.T., P.C. All right privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (No Fault Statue) 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 on the above-mentioned date, notwithstanding any other agreement to the contrary. THIS AGREEMENT MAY BE REVOKED BY THE ASSIGNEE AND/OR VIOLATION OF A POLICY CONDITION DUE TO THE ACTIONS OR CONDUCT OF THE ASSIGNOR.

X_____
Signature of the Patient/Parent/Guardian (ASSIGNOR)

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRUAD 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 ASSITS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FLASE REPORT OF THE THEFT, DESTRUCTION ,DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR 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 OR THE SUBJECT MOTOR VEHICLE OR STATTED CLAIM FOR EACH VIOLATION.

(Taken from the NYS FORM NF-AOB Rev 1/2004)

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Kindly furnish my insurance company or their representatives with all information you may have regarding my condition while under your treatment or observation, including the history obtained, X-ray and physical findings, diagnosis and prognosis. You are authorized to provide the information in accordance with the New York Automobile Reparations Act (No Fault Law)

X_____ DATE: _____
Signature of the Patient/Parent/Guardian

Name of the Insurance Carrier Handling this Claim: _____

Insurance Carriers Phone Number: _____

Name on Insured: _____ Relation to Insured: _____

Policy #: _____Claim #: _____

IF YOU HAVE A DEDUCTIBLE WITH YOUR NO-FAULT INSURANCE COMPANY AND IT IS TAKEN OUT OF OUR CLAIMS YOU WILL BE REPSONSIBLE FOR PAYMENT.