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 even 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: _____

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 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 may be furnished to the patient at a charge of $75/per page. A patient's chart may not be copied or reviewed by a 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 restrictions or transfers of their protected health information at any time.

III. Insurance Companies

A patient's 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 provider's 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

WORKMAN'S COMPENSATION ASSIGNMENT OF BENEFITS FORM

Provider: WILLIAM J. SCHWARZ, P.T., P.C.
5700 Merrick Road
Massapequa, NY 11758

AGREEMENT TO PAY MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE OR IF COMPENSATION CLAIM IS DISALLOWED

NYS WC LAW: YOU MAY NOT BE TREATED BY A CHIROPRACTOR WHILE BEING TREATED BY A PHYSICAL THERAPIST FOR THE SAME INJURY.

WBC CASE NO.:_____ CARRIER CASE NO.:_____

DATE OF INJURY: _____ INJURED PERSON SS#:_____

ADDRESS OF OCCURANCE: _____

INJURED PERSON: _____AGE:_____ PHONE: _____
FIRST MID INIT. LAST

EMPLOYER: _____ PHONE: _____

ADDRESS: _____

INSURANCE CARRIER: _____ PHONE: _____

ADDRESS:_____

REFERRING PHYSICIAN: _____

*If treatment was rendered under Volunteer Firefighter's Benefit Law show as EMPLOYER the liable political subdivision and enter "X" here ☐
In the event I fail to prosecute the claim for Workman's Compensation for this illness or condition or it is determined by the Workman's Compensation Board that the illness or condition is not a result of compensable Workman's Compensation case, I_____ hereby agree to pay the above named provider for usual and customary fees for services rendered to the above named claimant in the above identified case.

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-rays and physical findings, diagnosis and prognosis.

X_____
Signature or Patient/Parent/Guardian Date

PRIMARY INSURANCE INFORMATION:

In the even that my Workman's Compensation Benefits are denied, I hereby assign to the above service provider and/or their assignees so much of my first party insurance benefits and rights as shall equal the full amount of the bill for such services and the provider or their assignees may secure in my name.

Insurance Company name: _____ Phone: _____

Insurance Address: _____

Name of Insured: _____Relation: _____

Insured's Social Security #: _____ Policy/group#: _____

X_____
Signature of Patient
I also authorize this office to release any reports/findings to my referring physician.

X_____
Signature of Patient

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