# Crescent Physical Therapy P.C.

**Patient Information:**

Patient Name: _____ , _____ _____
(Last) (First) (Middle)

Home Address: _____

City: _____ State: _____ Zipcode: _____ Sex: Male/Female

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

Date of Birth: _____ Social Security #: _____

Emergency Contact: _____ _____ _____
Name Phone Number Relationship

**Insurance and Billing Information (IF NO FAULT WE STILL WANT PRIMARY INSURANCE ON FILE):**

**Primary Insurance:** Name of Insured: _____

Insured Relationship: Self ( ) Spouse ( ) Dependent ( )

Insurance Carrier: _____ Insurance ID # _____

Group# _____

Insurance Claims Address: _____

Co-pay Amount: _____ Insurance Phone # _____

**Secondary Insurance:** Name of Insured: _____

Insured Relationship: Self ( ) Spouse ( ) Dependent ( )

Insurance Carrier: _____ Insurance ID # _____

Group# _____

Insurance Claims Address: _____

**Name of Person Responsible for bill/payment if other than patient:** _____

**Insured Relationship: Self ( ) Spouse ( ) Dependent ( ) DOB:** _____

Phone Number: _____

Home Address: _____

City: _____ State: _____ Zipcode: _____

**Patient Signature** (X) _____ **Date** _____

***PLEASE FILL OUT ALL PAGES OF PATIENT INTAKE PACKET (1-5).**

**Crescent Physical Therapy P.C.**
**Medical History Questionnaire**

Name_____D.O.B./Age_____

Referring Physician_____ Next MD visit_____

Occupation/Occupational Activities _____

Missed Work Due to this Injury(Y/N) _____ Date(s) of Work Absence _____

Have you had Surgery for this injury (Y/N)_____Type of Surgery/Date_____

Are you taking any prescription or non-prescription medications for this injury? (please list)
_____
Are you taking any prescription or non-prescription medications for any other medical conditions? (please list)
_____

FOR THIS CONDITION:

Have you been treated by any of the following?

| | Yes | No |
|---|---|---|
| Physical Therapy | ___ | ___ |
| Neurologist | ___ | ___ |
| Orthopedist | ___ | ___ |
| Podiatrist | ___ | ___ |
| Chiropractor | ___ | ___ |
| Occupational Therapy | ___ | ___ |

Have you had any of these exams?

| | Yes | No |
|---|---|---|
| CT Scan | ___ | ___ |
| EMG/NCV | ___ | ___ |
| MRI | ___ | ___ |
| Myelogram | ___ | ___ |
| X-Rays | ___ | ___ |

Do you have or have you ever had ANY of the following?

| | Yes | No |
|---|---|---|
| Asthma | ___ | ___ |
| Bronchitis | ___ | ___ |
| Emphysema | ___ | ___ |
| Shortness of Breath | ___ | ___ |
| Coronary Artery Disease | ___ | ___ |
| Angina | ___ | ___ |
| High Blood Pressure | ___ | ___ |
| Heart Attack/Surgery | ___ | ___ |
| Pacemaker | ___ | ___ |
| Stroke/TIA | ___ | ___ |
| Allergies | ___ | ___ |
| Metal Implants/Pins | ___ | ___ |
| Joint Replacement | ___ | ___ |
| Diabetes | ___ | ___ |
| Infectious Disease | ___ | ___ |
| Cancer | ___ | ___ |
| Arthritis | ___ | ___ |
| Osteoporosis | ___ | ___ |
| Difficulty Sleeping | ___ | ___ |
| Neurological Problems | ___ | ___ |
| Varicose Veins | ___ | ___ |
| Emotional Problems | ___ | ___ |
| Vascular Problems | ___ | ___ |
| Lyme Disease | ___ | ___ |
| Do you smoke? | ___ | ___ |

| | Yes | No |
|---|---|---|
| Vision Difficulty | ___ | ___ |
| Hearing Difficulty | ___ | ___ |
| Dizziness or Fainting | ___ | ___ |
| Weakness | ___ | ___ |
| Weight Loss | ___ | ___ |
| Energy Loss | ___ | ___ |
| Hernia | ___ | ___ |
| Epilepsy/Seizures | ___ | ___ |
| Thyroid trouble/Goiter | ___ | ___ |
| Blood Clot/Emboli | ___ | ___ |
| Headaches | ___ | ___ |
| Incontinence | ___ | ___ |
| Bowel of Bladder Problem | ___ | ___ |
| Neck Injury/Surgery | ___ | ___ |
| Shoulder Injury/Surgery | ___ | ___ |
| Elbow/Hand Injury/Surgery | ___ | ___ |
| Back Injury/ Surgery | ___ | ___ |
| Knee Injury/Surgery | ___ | ___ |
| Ankle/Foot Injury/Surgery | ___ | ___ |
| Gout | ___ | ___ |
| Fibromyalgia | ___ | ___ |
| Chronic Fatigue | ___ | ___ |
| Anemia | ___ | ___ |
| Shingles | ___ | ___ |
| Are you pregnant? | ___ | ___ |

Please list any injury or illness not listed above _____
_____

**Crescent Physical Therapy, P.C.**
**Consent for Care and Treatment**

This is to certify that I, **the patient**, give authorized personnel of Crescent Physical Therapy, PC, permission to provide physical therapy treatment that is considered prudent medical practice for my illness, injury or condition. Please be aware that certain treatments may require close proximity and/or manual contact.

**Signature of patient** (X) _____

**Print Patient Name** _____ **Date**_____

_____ _____

## Billing Policy, Release, and Authorization

I authorize Crescent Physical Therapy, PC or their representatives (DR Advantage, LLC) to bill my insurance company directly for the covered portion of charges, and I authorize payment of medical benefits directly to Crescent Physical Therapy, PC. I authorize Crescent Physical Therapy, PC or their representatives to release medical or other information necessary to process this claim. I understand that I am ultimately responsible for my physical therapy charges and agree to pay my coinsurance, copayment, any applicable deductible, and any charges not reimbursed by my insurance carrier. I understand that some insurance companies require medical or administrative pre-authorization for treatment, or have reimbursement limits on physical therapy treatment. I understand that I am responsible for knowing and meeting the requirements of my insurance plan, or those mutually agreed upon by myself and Crescent Physical Therapy, PC, and stated below. **I understand that if insurance checks are mailed to me, I must endorse them and make payable to Crescent Physical Therapy, PC.**

Please pay the balance in full at the time of service or upon receipt of monthly statement or notice. In the event that you are unable to pay the balance in full, we will attempt to make reasonable payment arrangements (agreeable to both parties). Please be advised that Crescent Physical Therapy, PC is not a credit guarantor, and therefore failure to maintain these arrangements could result in the placement of your account with a collection agency (patient will then be responsible for any fees incurred in this event). Self Pay patients please initial_____.

I, the patient am responsible to inform Crescent Physical Therapy, PC of any changes in my insurance status in a timely fashion. Any charges that are not reimbursed due to a change in my insurance without appropriate notification to Crescent Physical Therapy, PC will be my self-pay responsibility.

**Patient Responsibility**_____

**Print Name**_____ **Patient Signature** (X) _____

**Date**_____ **Crescent Physical Therapy, PC** _____

_____ _____

**Crescent Physical Therapy - Notice of Patient Privacy Acts**

THIS NOTICE DESCRIBES HOW MEDICAL AND PERSONAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS FORM CAREFULLY.

## OUR LEGAL DUTY

Crescent Physical Therapy, PC is required by law to protect the privacy of your personal and health information, provide notice about our information management practices, and follow the information protocols described below.

## USES AND DISCLOSURES OF HEALTH INFORMATION

Crescent Physical Therapy, PC, uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and assessing the quality of care we are proud to provide. We use your personal information to contact you to arrange appointments with us and to properly bill your insurance carrier for the services we provide you with. Crescent Physical Therapy, PC may use the phone numbers designated by you, leave a message or voicemail message, or mail to your home, information regarding appointments, billing or other necessary correspondence, marked personal and confidential. In addition, we may, from time to time, disclose your health information without prior authorization for public health purposes, auditing tracking and research studies. In any other situation, Crescent Physical Therapy, PC will obtain your written permission and authorization before disclosing your personal health information. If you provide us with written authorization to release your information for any reason, you may later revoke that authorization to cease future disclosures at any time. If and when any changes are made in our privacy and confidentiality policies, a new Notice of Information Practices will be posted in the same area for public view. You may request a copy of our Notice of Information Practices at any time. HIPAA Compliance Officer is Khurram Khan. He can be called at 917-685-5954.

## PATIENT'S INDIVIDUAL RIGHTS

You have the right to obtain a copy of your personal health information at any time. You have the right to request that we correct inaccurate or incomplete information in your records. You also have the right to request a list of instances where we disclosed your personal health information for reasons other than treatment, payment, or administrative purposes except when specifically authorized by you, when required by law, or in an emergency. Crescent Physical Therapy, PC will consider all such requests on a case-by-case basis. The company is not legally required to accept such requests.

## CONCERNS AND COMPLAINTS

If you are concerned that Crescent Physical Therapy, PC may have violated your privacy rights or if you disagree with any decisions that we have made regarding access or disclosure of your personal health information, please contact our HIPAA Compliance Officer, Khurram Khan, at the office address and phone number listed below. You may also send a written complaint to the U.S. Department of Health and Human Services.

**Crescent Physical Therapy, PC**
**Attention: Khurram Khan/HIPAA Compliance Office/ #718-545-0999**
**21-24 30th Ave Suite C-1**
**Astoria, NY 11102**

I authorize all medical and personal information to be released on my behalf to Crescent Physical Therapy's Billing Service, DR Advantage. Use is restricted to coding medical conditions for the express purpose of generating a bill for the patient's insurance company.

I _____, acknowledge that I have received, read, and understand the information regarding Crescent Physical Therapy, PC's patient information processes. My signature allows Crescent Physical Therapy, PC to use my protected health information for treatment, payment and healthcare operations.

I make the following special requests for confidential communication _____
_____

Signature (X) _____ Date_____

_____ _____

# CRESCENT PHYSICAL THERAPY P.C.

## Certification of Non-Worker's Compensation or Non-No Fault Injury

I , (PRINT NAME)_____, certify the physical therapy I am seeking for this injury/accident/ surgery is not related to ANY injury or accident that is work related or from a car accident.

Signature ⓧ _____Date_____

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IF NOT WORK INJURY OR CAR ACCIDENT DO NOT FILL OUT BELOW.

## NO FAULT / WORKER'S COMPENSATION

NAME _____

CLAIM # _____

POLICY # _____

DATE OF ACCIDENT/INJURY: _____

ADJUSTER'S NAME: _____

ADJUSTER'S PHONE # _____

ADJUSTER'S ADDRESS: _____

_____

_____

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DO NOT FILL OUT BELOW THIS LINE. INFORMATION TO BE FILLED OUT BY OFFICE STAFF ONLY

CASE: OPEN CLOSED

PRIOR AUTHORIZATION: YES NO

FROM: _____

DATE: _____

Initials: _____

Spoke to : _____