Crescent Physical Therapy P.C. No Fault Accident Intake

Patient Information:

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

Home Address: ____

City: ______________ State: ______________ Zipcode: __________ Sex: Male/Female

Home Phone: ____________________ Cell Phone: ____________________

Date of Birth: ____________________ Social Security #: ____________________

EMAIL Address: ____

Emergency Contact: ____________________ ____________________ ____________________
Name Phone Number Relationship

NO-FAULT INFORMATION

INSURANCE NAME____

CLAIM # ____________________WCB #____________________

DATE OF ACCIDENT/INJURY: ______________________________

ADJUSTER'S NAME: ______________________________

ADJUSTER'S PHONE # ______________________________

ADJUSTER'S ADDRESS: ______________________________

____

____

Patient Signature ⓧ ____________________ **Date** ____________________

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 : ______________

Crescent Physical Therapy P.C. - Medical History Questionnaire

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? (list them)

____

Are you taking any prescription or non-prescription medications for any OTHER medical conditions? (please list) ____

____

Have you had any of these exams?
CT Scan ___ EMG ___ MRI ___ X-Rays ___
If you have the medical reports for these exams please give a copy to the front desk now.
Do you have or have you ever had ANY of the following (Please check all that apply)

High Blood Pressure	___	Heart Attack/Surgery	___
Pacemaker	___	Blood Clot/Emboli	___
Metal Implants/Pins	___	Diabetes	___
Cancer	___	Are you pregnant?	___

Please list any pertinent medical history not listed above ____________________________

____

Patient Signature ⓧ ______________________________ **Date** ________________

____

FOR THIS ACCIDENT: Did you ever have physical therapy before? **YES NO**

When did you have physical therapy? ________________ (DATE)

How many total visits used?________________

Patient Signature ⓧ ______________________________ **Date** ________________

____

Independent Medical Examination

For this accident I am scheduled for an Independent Medical Examination with a doctor representing No Fault on: ________________ (DATE).

I am not scheduled currently, but as soon as I am scheduled I will inform the front desk at Crescent Physical Therapy P.C.

Patient Signature ⓧ ______________________________ **Date** ________________

____

Consent for Care and Treatment

This is to certify that I, **the patient/guardian**, 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.

Patient Signature ⓧ ______________________________ **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 and will incur fees.

Agreement To Pay: I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary.

I, the patient am responsible to inform Crescent Physical Therapy, PC of any changes to my insurance immediately.

Any charges that are not reimbursed by my insurance will be billed to me and will be my out of pocket expense.

Patient Signature ⓧ ______________________ **Date**__________________

Consent to Contact Patient by Telephone

You agree, in order for us to service your account or to collect monies you may owe, Crescent Physical Therapy, PC and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.
I/We have read this disclosure and agree that Crescent Physical Therapy, PC, its employees and/or agents may contact me/us as described above.

Patient Signature ⓧ ______________________ **Date**__________________

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 718-545-0999.

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 ⓧ ____________________ Date______________________________

CRESCENT PHYSICAL THERAPY P.C.
LATENESS AND CANCELLATION POLICY

In order for each patient to achieve maximum benefit from Physical Therapy, it is of absolute importance that patients come regularly to Physical Therapy. Usually patients come in 2-3 times per week depending on the frequency recommended by your doctor.

All patients must be on time for their scheduled appointment. If you are late, **you must call** to inform Crescent Physical Therapy P.C. of your arrival time.

If you need to cancel your appointment, **you must call** to inform Crescent Physical Therapy P.C. that day.

If you do not call and cancel your appointment we will have to charge you a $10.00 cancellation fee.

Thank You for your cooperation.

I understand the above late cancellation policy.

Patient Signature ⊗ ______________________ **Date** ______________________

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

Form Reviewed by Crescent Physical Therapy, PC employee

Employee Signature ⊗ ______________________ Date __________

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
(This form is not for verification of hospital treatment)

NAME AND ADDRESS OF INSURER OR SELF-INSURER*	NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

PROVIDER'S NAME AND ADDRESS*	Khurram Khan/ Crescent Physical Therapy 21-24 30th Ave Suite C-1 Astoria, N.Y. 11102

KINDLY COMPLETE AND SUBMIT THIS FORM AS SOON AS POSSIBLE. **PLEASE NOTE, THIS COMPLETED FORM MUST BE SUBMITTED TO THE INSURER AS SOON AS REASONABLY POSSIBLE BUT NO LATER THAN 45 DAYS OR 180 DAYS AFTER THE TREATMENT DATE, DEPENDING UPON THE POLICY ENDORSEMENT IN EFFECT AT THE TIME OF THE ACCIDENT. IF YOU ARE UNSURE OF THE APPLICABLE TIME REQUIREMENT, KINDLY CONTACT THE CLAIMS REPRESENTATIVE TO DETERMINE WHICH DEADLINE IS APPLICABLE TO THIS CLAIM.**

IF YOU HAVE PREVIOUSLY SUBMITTED AN EARLIER REPORT ON THIS ACCIDENT, YOU NEED ONLY NOTE ANY CHANGES FROM THE INFORMATION PREVIOUSLY FURNISHED AND ADDITIONAL CHARGES.

1. PATIENT'S NAME AND ADDRESS

2. DATE OF BIRTH | 3. SEX | 4. OCCUPATION (IF KNOWN)

5. DIAGNOSIS AND CONCURRENT CONDITIONS

6. WHEN DID SYMPTOMS FIRST APPEAR? DATE: ________

7. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? DATE: ________

8. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?

YES [ ] NO [X] IF YES, state when and describe:

9. IS CONDITION SOLELY A RESULT OF THIS AUTOMOBILE ACCIDENT?

YES [X] NO [ ] IF "NO", explain:

10. IS CONDITION DUE TO INJURY ARISING OUT OF PATIENT'S EMPLOYMENT?

YES [ ] NO [X]

11. WILL INJURY RESULT IN SIGNIFICANT DISFIGUREMENT OR PERMANENT DISABILITY?

YES [ ] NO [ ] NOT DETERMINABLE AT THIS TIME [X]
IF "YES", describe:

12. PATIENT WAS DISABLED (UNABLE TO WORK)

FROM: ________ THROUGH: N/A

13. IF STILL DISABLED THE PATIENT SHOULD BE ABLE TO RETURN TO WORK ON:

N/A
(DATE)

CONTINUE ON PAGE 2

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
PAGE 2

14. WILL THE PATIENT REQUIRE REHABILITATION AND/OR OCCUPATIONAL THERAPY AS A RESULT OF THE INJURIES SUSTAINED IN THIS ACCIDENT?

YES [X] NO [ ] IF YES, describe your recommendation below:

PT requires physical therapy to address pain, decreased mm strength, decreased Rom, decreased function.

15. REPORT OF SERVICES RENDERED -- ATTACH ADDITIONAL SHEETS IF NECESSARY

DATE OF SERVICE	PLACE OF SERVICE INCLUDING ZIP CODE	DESCRIPTION OF TREATMENT OR HEALTH SERVICE RENDERED	FEE SCHEDULE TREATMENT CODE	CHARGES
	21-24 30th Ave Suite C-1 Astoria, N.Y. 11102	PT Evaluation Manual Therapy, Electric Stimulation Therapeutic Exercises.	97110 97140 97014 97001	SEE BILL
			TOTAL CHARGES TO DATE$	

16. IF TREATING PROVIDER IS DIFFERENT THAN BILLING PROVIDER COMPLETE THE FOLLOWING:

TREATING PROVIDER'S NAME	TITLE	LICENSE OR CERTIFICATION NO.	BUSINESS RELATIONSHIP CHECK APPLICABLE BOX		
			EMPLOYEE	INDEPENDENT CONTRACTOR	OTHER (SPECIFY)

17. IF THE PROVIDER OF SERVICE IS A PROFESSIONAL SERVICE CORPORATION OR DOING BUSINESS UNDER AN ASSUMED NAME (DBA), LIST THE OWNER AND PROFESSIONAL LICENSING CREDENTIALS OF ALL OWNERS (Provide an additional attachment if necessary).

Khurram Khan, Physical Therapist

18. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES [X] NO [ ]

19. ESTIMATED DURATION OF FUTURE TREATMENT

PATIENT: Your health provider may agree to accept payment for health services performed directly from your insurer (**Authorization to Pay Benefits**) so that you are not required to make payment to the health provider at the time of service. Such agreement is optional on the part of the health provider and must be signed by both patient and health provider. You may use the optional authorization language provided below, by checking off the designated spot in item 20 of this form.

20. ______ (IF YOU HAVE CHOSEN TO AUTHORIZE THE DIRECT PAYMENT OF BENEFITS BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN ASSIGNMENT OF BENEFITS CONTAINED IN #21)

AUTHORIZATION TO PAY BENEFITS:

I AUTHORIZE PAYMENT OF HEALTH BENEFITS TO THE UNDERSIGNED HEALTH CARE PROVIDER OR SUPPLIER OF SERVICES DESCRIBED BELOW. I RETAIN ALL RIGHTS, PRIVILEGES AND REMEDIES TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT PROVISION) OF THE INSURANCE LAW.

PRINT NAME ______________________ SIGNED ______________________ ________
PATIENT PATIENT DATE

CONTINUE ON PAGE 3

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE

PATIENT: Your health provider may agree to have you assign your right to No-Fault benefits from your insurer directly to your health provider (**Assignment of Benefits**). If you and your health provider agree to an assignment of benefits, you must both sign the agreement contained in # 21 or the prescribed NF-AOB form or its equivalent. The language contained in the assignment of benefits is mandatory and may not be altered or avoided by any other language added to this agreement or other written agreement.

21. ______ (IF YOU HAVE CHOSEN TO ASSIGN YOUR BENEFITS TO THE HEALTH PROVIDER BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN AUTHORIZATION TO PAY BENEFITS CONTAINED IN ITEM #20 ABOVE)

ASSIGNMENT OF NO-FAULT BENEFITS:

I HEREBY ASSIGN TO THE HEALTH CARE PROVIDER INDICATED BELOW ALL RIGHTS, PRIVILEGES AND REMEDIES TO PAYMENT FOR HEALTH CARE SERVICES PROVIDED BY THE ASSIGNEE TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT STATUTE) 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, NOTWITHSTANDING ANY OTHER AGREEMENT TO THE CONTRARY. THIS AGREEMENT MAY BE REVOKED BY THE ASSIGNEE WHEN BENEFITS ARE NOT PAYABLE BASED UPON THE ASSIGNOR'S LACK OF COVERAGE AND/OR VIOLATION OF A POLICY CONDITION DUE TO THE ACTIONS OR CONDUCT OF THE ASSIGNOR

PRINT NAME ______________________ SIGNED ______________________
PATIENT (Assignor) — PATIENT — DATE

PRINT NAME Khurram Khan SIGNED ______________________
PROVIDER OF HEALTH CARE SERVICE (Assignee) — PROVIDER OF HEALTH CARE SERVICE — DATE

HAS AN ORIGINAL AUTHORIZATION OR ASSIGNMENT PREVIOUSLY BEEN EXECUTED? [X] YES [ ] NO

IS THE ORIGINAL SIGNATURE OF THE PARTIES ON FILE? [X] YES [ ] NO

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

DATE	PROVIDER'S SIGNATURE	IRS/TIN IDENTIFICATION NO.	WCB RATING CODE IF NONE, SPECIALTY
		20-3072350	

*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, ______________________, ("Assignor") hereby assign to Khurram Khan **, ("Assignee")**
(Print patient's name) (Print hospital or health care provider name)
all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) 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 which occurred on ______________, not withstanding any other agreement
(Print accident date)
to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

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

____
(Print name of Patient)

____
(Signature of Patient)

____

____
(Date of signature)

____
(Address of Patient)

Crescent Physical Therapy/ Khurram Khan
(Print name of Provider)

____
(Signature of Provider)

21-24 30th Avenue Suite C-1

____
(Date of signature)

Astoria, N.Y. 11102
(Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)