Crescent Physical Therapy, P.C. – Private/Mcaid HMO Insurance 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

Insurance and Billing Information:

Primary Insurance: _____

Co-pay Amount: _____ Insurance Phone # _____

Secondary Insurance: _____

IF YOU DON'T HAVE A SECONDARY INSURANCE PLEASE SIGN BELOW

I, (print name) ⓧ_____, certify that I do not have a secondary insurance.

All information provided above is certified to be true and accurate.

Patient Signature ⓧ_____ **Date** _____

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

Crescent Physical Therapy P.C. - Medical History Questionnaire

Missed Work Due to THIS Injury(Y/N) _____ Date(s) of Work Absence _____
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 (X) _____ **Date** _____

FOR ANY CONDITION: Did you ever have physical therapy before? **YES NO**

When did you have physical therapy? _____ (DATE)

How many total visits used?_____

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

Certification of Non-Worker's Compensation or Non-Car Accident/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.

Patient Signature (X) _____ **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.

Signature of patient/guardian (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 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 (X) _____ **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 (X) _____ **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 (X) _____ 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 _____