PATIENT DATA FORM

NAME: ______________________________ HOME TELEPHONE#: ______________________
CEL#: ____________________________________
ADDRESS: ____________________________ EMAIL: ____________________________________

CITY/STATE/ZIP: ____ MALE/FEMALE(please circle)

DATE OF BIRTH: ____________ SOC. SEC.# ____________________ MARITAL STATUS ________

EMPLOYMENT INFORMATION REFERRED BY: ____________________________________

EMPLOYER: ___________________________ EMPLOYEE TELE.# _________________________

ADDRESS: ____________________________ CITY/STATE/ZIP: ___________________________

IF WE ARE UNABLE TO CONTACT YOU, PLEASE LIST THE NAME OF SOMEONE ELSE WE CAN CALL IN CASE OF AN EMERGENCY OR IF WE NEED TO CHANGE YOUR APPOINTMENT.

NAME: ______________________________ TELEPHONE: ______________________________

RELATIONSHIP: _________________________

HEALTH INSURANCE INFORMATION (please give your insurance card to the receptionist)

PRIMARY HEALTH INSURANCE CARRIER: ____

INSURANCE CARRIER TELEPHONE#: ____

INSURED'S NAME: ____
(if different from patient)
INSURED'S DATE OF BIRTH: ____

IDENTIFICATION, GROUP AND/OR PLAN #'S: _______________________________________

SECONDARY HEALTH INSURANCE CARRIER: ____

INSURANCE CARRIER TELEPHONE#: ____

INSURED'S NAME: ____
(if different from patient)
INSURED'S DATE OF BIRTH: ____

IDENTIFICATION, GROUP AND/OR PLAN #'S: _______________________________________

IF MOTOR VEHICLE OR WORKMAN'S COMPENSATION, PLEASE COMPLETE THE FOLLOWING:

COMP. OR NO FAULT CARRIER: ____
(please circle one)
ADDRESS: ________________________________ CITY/STATE/ZIP: ____________________________

DATE OF ACCIDENT:_______________________ ADJUSTER'S NAME: ________________________

CLAIM/POLICY #'S: ________________________ TELEPHONE#: ______________________________

Please be advised the following is our office policy:

All professional services are charged to the patient. Necessary forms will be used to expedite insurance carrier payments.

If you are covered by workman's compensation or no-fault insurance, your bills will be sent to their respective insurance carriers. If for any reason there remains a balance after your "Auto Carrier" has paid and reductions have been taken from your account based on the reasonable and customary fees in our geographical area, you will be held responsible for all balances remaining. We do not except LITIGATION. Although, if you should have any major medical insurance that you would like us to bill the balance to, please provide us with this information now.

If we are billing your health insurance, all co-pays must be paid at the time services are rendered. We are presently accepting personal checks, cash or money orders. Your insurance is a contract between you, your employer and the insurance company. We are not a party of that contract. While the filing of insurance claims is a courtesy that we extend to our patients, you are responsible to know if your plan has a deductible, co-pay/co-insurance, limitations or restrictions. All charges are your responsibility unless other arrangements have been made in advance.

Further, you as the patient will be held responsible for the legal costs associated with obtaining payment should you fail to pay for any amounts further to services or treatment rendered which are not covered by your insurance carrier.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize all information to be furnished to my insurance carriers concerning my illness and treatments and I hereby assign to David M. Feniger, PT / Broadway Physical Therapy all payments for any services rendered to my self and my dependents.

Your signature signifies you have read and understood the above.

DATE: __________ PATIENT SIGNATURE: ____
SIGNATURE (IF MINOR):____

YOU MUST GIVE 24 HRS. NOTICE IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT. A $25.00 FEE WILL BE CHARGED TO YOU FOR ALL MISSED APPOINTMENTS.

"A copy of this form shall be deemed as valid and effective as the original"

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _______________________, understand that as part of my health care, Broadway Physical Therapy originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Broadway Physical Therapy is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Broadway Physical Therapy reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Broadway Physical Therapy change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:
____
____
____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

____
Patient's Signature

____
Date

FOR OFFICE USE ONLY

[ ] Consent received by _______________________________ on _____________________.

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on __________________________.

PATIENT FINANCIAL AGREEMENT FORM

I consent that I am responsible for any/all charges assigned to me by my insurance company including, but not limited to, yearly deductibles, co-insurances, co-pays, non-plan coverages, etc. __________ (patient's initials)

In the event that I receive payment from my insurance company for services rendered, I agree to pay the full amount of payment to Broadway Physical Therapy. __________ (patient's initials)

I consent that I understand and will abide by the following administrative fees. _____________(patient's initials)

Return payment for Non-Sufficient Funds	$25.00
Request for release of medical records	$15.00

LITIGATION/THIRD PARTY CLAIMS

Patients who are being treated with the understanding that their charges will be pended until the settlement of their case, must furnish this office with a Letter of Protection/Guarantee from their attorney prior to initial treatment. This agreement states the patient clearly understands the outstanding balance is due upon the settlement of his/her case **WHETHER OR NOT** the suit is in favor of the patient or the responsible party in involved.

______________________________ ____________________

SIGNATURE TODAY'S DATE

ATTORNEY INFORMATION:

Name/Firm: _______________________ Telephone Number: ________________

NO SHOW POLICY

Please be advised a $65.00 No Show fee will be charged to your account and must be paid in full before you resume treatment. Patient will receive a warning on the first No Show.

Patient's Initials: __________________