Western New York Physical & Occupational Therapy Group, PLLC

NEW PATIENT INFORMATION SHEET

Allergies ____________________________________

Name____Home Phone _________________E-mail address____________________

Address ____ City ________________________ State __________ Zip _____________

Date of Birth ___________________ Social Security Number _________________________ Marital Status___________________

Place of Employment _____________________________ Occupation____________________ Work Phone ____________________

In case of emergency contact____ Phone Number_________________________

Address ____ Relationship __________________

Second emergency contact ___________________________ Phone Number ________________ Relationship __________________

Referring Physician _____________________________________ Family Physician _______________________________________

☐ *GENERAL INSURANCE INFORMATION*

Primary Insurance ___________________________________ Secondary Insurance ____

Subscriber's Name __________________________________ Subscriber's Name ____

Subscriber's Date of Birth ____________________________ Subscriber's Date of Birth ___________________________________

Certificate or ID# ___________________________________ Certificate or ID# ____

Group or Access # __________________________________ Group or Access # ____

Authorization # (*When Applicable*) _______________________ Authorization # (*When applicable*) _______________________________

☐ *NO-FAULT INSURANCE INFORMATION*

Insurance Company Name ____ Phone Number ______________________

Address ____ City ________________________State _________ Zip ____________

Policy #___________________________ Claim/File # ____________________________ Date of Injury ________________________

Insured's Name ____ Was a motorcycle or DWI involved? _____ Yes _____ No

☐ *WORKERS' COMPENSATION INSURANCE INFORMATION*

Employer ____ Work phone ____________________________

Address ____ City ________________________ State ____________ Zip ____________

Insurance Carrier Name ____ Phone number _________________________

Address ____ City ________________________ State ____________ Zip ____________

WCB# _________________________ Carrier Case # __________________________ Date of Injury __________________________

Insurance Adjuster ____ Are you working now ? _____ Yes ______ No

Address where injury occurred ____

I hereby certify that the information above is, to the best of my knowledge, complete and accurate. I understand that I am financially responsible to Western New York Physical & Occupational Therapy Group, PLLC for all therapy services rendered at this clinic whether or not covered by insurance. I also hereby authorize release of information pertaining to my medical condition and therapy treatment to my insurance company, Social Security Administration or Medicare program.

SIGNATURE ____

****

STATEMENT TO AUTHORIZE PAYMENT OF BENEFITS

I certify that the information given by me in applying for payment is correct. I authorize WNY Physical & Occupational Therapy Group, PLLC to release any medical information required to process my claim. I request that payment be made to WNY Physical & Occupational Therapy Group, PLLC for services provided to me.

SIGNATURE____ DATE _____________________

(revised 10/08)

WESTERN NEW YORK PHYSICAL & OCCUPATIONAL THERAPY GROUP, PLLC

PATIENT HISTORY AND TREATMENT CONSENT

Name:____

Occupation:_______________________________________Are you working now?___________

Describe your job:____

Describe your injury or symptoms:____

How did your injury occur? ____
(Continue on reverse if more room is needed)

What are your goals/expectation of your therapy treatment: _________________________________

Have you ever received Physical Therapy for this condition/injury?_____________________________
Are you presently being treated by a chiropractor?________ Have you had: X-rays/MRI/CAT Scan (circle)
Have you had any of the following? (Please check)

_____ Diabetes (IDDM or NIDDM) ____Migraine Headaches ____Neurological problems (numbness, weakness, tremors, seizures)
_____ Rheumatic Fever ____Varicose veins ____Heart murmur (please explain)_______________
_____ Cancer ____Circulatory problems ____Lung Disease
_____ Stroke ____Hypertension ____Epilepsy/seizures
_____ Broken Bones (fracture) ____Heart Disease ____Arthritis
_____ Kidney disease ____Osteoporosis ____Allergies______________________________
_____ Metal Implants ____Liver Disease ____Current Infection ______________________
Other________________________________

List any medications you are presently taking: ____

____

List any surgeries you have had:____

Do you smoke?______ Have a pacemaker? ______ Exercise regularly?_______ Chest discomfort?_____

Females: Is there a chance you may be pregnant at this time?_________________

What was your primary reason for choosing our facility for physical therapy? Please X choice.

	Primary Physician Recommendation		Specialist Physician Recommendation		Insurance Co./Directory		Rehab Nurse Recommendation
	Radio Ad		Newspaper or Magazine Ad		Friend/Family		Verizon Telephone Book
	Contact with staff member		Coach		Website		Talking Phone Book
	Previously treated here		Convenient location		Other		Television Commercial

I authorize WNY Physical & Occupational Therapy Group, PLLC, to render Physical and/or Occupational therapy care pursuant to a referral from a licensed physician, dentist, podiatrist, physician's assistant or nurse practitioner in accordance with Federal and NY State Law. I understand that I have the right to consent to; or refuse to consent to; any proposed therapy procedure after receiving information about the benefits and possible associated risks.

_____________________________ _____________________________ _______________
Patient Signature/Legal Guardian Therapist Signature Date

Updated: January 12, 2016

Western New York Physical & Occupational Therapy Group, PLLC

Consent for Disclosure of PHI

I understand that as part of my treatment, payment for my treatment, and health care operations (TPO), it may be necessary to disclose my Protected Health Information (PHI) to another entity. I consent to such disclosure for these purposes via telephone, dedicated/secured fax or safeguarded e-mail.

Yes No

You may contact me by phone at home.

You may contact me by phone at work.

You may leave messages on my answering machine/voice mail or
___anyone in my household
___only with (give names)______________________________________

You may contact me by e-mail.

In addition to the standard (TPO) disclosures listed above, you may also disclose my Private Health/Billing information to the following person/persons in order for them to assist me in my care:____.

___*I have been advised that I may view the Notice of Privacy Practices from WNY Physical & Occupational Therapy Group PLLC in their waiting room, on their website, or request an electronic or paper copy if desired.

Patient Name:____

Patient Signature/Representative:_______________________________ Date:_______________

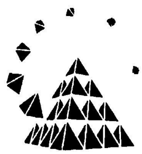
Relationship to patient:____

For office use only

____ Patient refused to read/sign
____ Patient is unable to sign
____ Patient is unable to read. The staff read the information to the patient.

Staff Signature:____

If you have any questions about the HIPAA Privacy Rules, please contact Privacy Officer, at 716-684-0400.



Western New York Physical & Occupational Therapy Group, PLLC

General Insurance/Financial Information

Welcome to **Western New York Physical & Occupational Therapy Group, PLLC**. We thank you and your physician for choosing our practice for your rehabilitation services.

Your insurance plan requires a written order (prescription) from a NYS licensed medical doctor, osteopathic doctor, physician assistant, nurse practitioner, podiatrist or dentist in order for treatment to be rendered. The prescription is valid from the date of your initial visit for the time period specified by your physician. If there is no time period specified on your script, it is only valid for 30 days from the date written. It is the patient's responsibility to obtain a new prescription each time the previous prescription expires.

WNY PT & OT is pleased to offer our patients the courtesy of participating with most major insurance plans:

AETNA (MagnaCare Network)
BCBS OF WNY
COMMUNITY BLUE
FIDELIS CARE
GHI
INDEPENDENT HEALTH
LIFETIME BENEFIT SOLUTIONS (formerly RMSCO)
MEDICARE PART B
MERITAIN HEALTH
NOVA
NYS EMPIRE PLAN (Managed Physical Network)
POMCO
RAILROAD MEDICARE (separate handout)
SENECA NATION OF INDIANS
THERAMATRIX
TRICARE/CHAMPUS
UNITED HEALTHCARE
UNIVERA HEALTHCARE
UNIVERSAL AMERICAN ó Today's Options
YOURCARE HEALTH PLAN

Benefit quotes are not a guarantee of payment as they are subject to plan provisions and based upon information currently available.

ó **ACCEPT INSURANCE:** If you have one of the above insurance plans, we agree to bill your plan directly and accept assignment as directed by the plan. If your plan requires a referral or preauthorization for physical or occupational therapy services, it may be your responsibility to have the referral/preauthorization in place by your initial visit.

PRIVATE INSURANCE: ____ WNY PT & OT Group is **non-participating** with your health plan and is not subject to any plan provisions. As a courtesy to you, we will bill your health plan directly if you have all the necessary information with you today. The fee for your treatment is based on the services rendered and may vary with each visit. If payment is not received from your insurance plan within 60 days from our billing date, we may require payment from you.
Liability cases (personal injury not on your property) are billed to the insurance carrier only if there is written authorization of payment on file at the time of your initial visit.

FINANCIAL RESPONSIBLITY: Your insurance plan, a contract between you and the carrier, requires that copays/coinsurance be made. **The copay/coinsurance amounts are due at the time of service.** Additional financial responsibilities may include deductible and õnon-covered servicesö based on your health planøs provisions. Cash, check, credit card payments are accepted.

Any questions regarding your account can be directed to our Billing Department by calling 684-0400 Monday through Friday 8:00 am to 5:00 pm. Our patient account representatives will be happy to answer your questions and address your concerns.

Your signature below certifies that you have read and understand the information provided regarding your insurance plan and financial responsibility as they pertain to PT/OT.

SIGNATURE ____DATE _____/_____/_____
(Patient or Responsible Party)