BARRY GOLDMAN PHYSICAL THERAPY

Barry Goldman Physical Therapist PLLC
7001 Amboy Road Staten Island, NY 10307
Phone: 718.227.4400 | Fax: 718.227.4401

PATIENT INTAKE FORM

Patient Name: _____ DOB: ____/____/____
Last First MI
Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Mobile: (____) _____

Sex: M F Other Marital Status: Married / Single / Other Email Address: _____

Is your condition related to: Employment: Y N or Auto Accident Y N

Injury Date: _____ Surgery Date: _____ Referring Physician: _____

INSURANCE INFORMATION

Name of Insurance: _____ Insured's Name: _____

Relationship to insured (circle one): SELF SPOUSE CHILD OTHER Insured's DOB: ___/____/____

EMPLOYMENT INFORMATION

FULL SS#: _____ (REQUIRED TO PROCESS WORKER'S COMPENSATION CLAIMS)

Employment Status: Full Time Part Time Unemployed Other: _____

Insured's Employer Name: _____ Insured's Employer Phone #: _____

Insured's Employer Address: _____ City: _____ State: _____ Zip: _____

Are you currently unable to work? Y N If yes, as of what date? _____

BARRY GOLDMAN PHYSICAL THERAPY

Barry Goldman Physical Therapist PLLC
7001 Amboy Road Staten Island, NY 10307
Phone: 718.227.4400 | Fax: 718.227.4401

BASIC MEDICAL HISTORY

1. Please inform us of any medical conditions we should be aware of (i.e.: pacemaker, heart condition, diabetes, etc.):

_____

2. Do you have any allergies we should be aware of? If yes, please list:

_____

3. Are you currently taking any medications? If yes, please list:

_____

4. Are you pregnant or think you may be pregnant? Y N N/A

5. Are you **currently** receiving treatment for this or any other injury (including physical therapy, chiropractic care, acupuncture, etc.) at another office: Y N If **yes**, please list what type of treatment and where:

_____

PATIENT INSURANCE AUTHORIZATION

Patient Name: _____

I request that payment of authorized insurance benefits be made on my behalf to: ***Barry Goldman Physical Therapist PLLC*** for any service provided to me by that physician/therapist/supplier. I authorize any holder of medical information about me to release to ***Barry Goldman Physical Therapist PLLC*** and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. "If other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Patient's/Guarantor's Signature Date

BARRY GOLDMAN PHYSICAL THERAPY

Barry Goldman Physical Therapist PLLC
7001 Amboy Road Staten Island, NY 10307
Phone: 718.227.4400 | Fax: 718.227.4401

FINANCIAL LIABILITY/ PATIENT RESPONSIBILITY AGREEMENT

I am aware that in the event that:

1) There is a co-payment, deductible or co-insurance on my policy;
2) There is a discrepancy made by my insurance representative during the verification of my benefits by ***Barry Goldman Physical Therapist PLLC***, as insurances state upon verification of benefits, that the benefits they give are not a guarantee of payment and are subject to change at any time;
3) My insurance changes and/or terminates and I fail to inform ***Barry Goldman Physical Therapist PLLC;***
4) I have utilized Physical Therapy visits elsewhere and fail to inform ***Barry Goldman Physical Therapist PLLC;***
5) I have maxed my Physical Therapy visits allowed on my policy and/or authorization and ***Barry Goldman Physical Therapist PLLC*** has made me aware of this and I still decide to attend further sessions;

I will be held responsible, and I hereby agree to pay ***Barry Goldman Physical Therapist PLLC*** fees for services rendered if and when any of the above-mentioned circumstances arise.

_____ _____

Patient's/Guarantor's Signature Date

WORKERS' COMPENSATION AGREEMENT

In the event I fail to prosecute the Workers' Compensation claim for the illness or condition or is determined by the Workers' Compensation Board that the illness or condition is not a result of a compensable Workers' Compensation case, I (print name) _____ hereby agree to pay ***Barry Goldman Physical Therapist PLLC*** fees for services rendered to the above named claimant in the identified case.

_____ _____

Patient's Signature Date

BARRY GOLDMAN PHYSICAL THERAPY

Barry Goldman Physical Therapist PLLC
7001 Amboy Road Staten Island, NY 10307
Phone: 718.227.4400 | Fax: 718.227.4401

PATIENT HIPAA AWARENESS

With my permission, ***Barry Goldman Physical Therapist PLLC*** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to ***Barry Goldman Physical Therapist PLLC's*** Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. ***Barry Goldman Physical Therapist PLLC*** reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the privacy officer.

With my permission, the office of ***Barry Goldman Physical Therapist PLLC*** may call my home or other designated locations and leave a message on voice mail in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of ***Barry Goldman Physical Therapist PLLC*** may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements, as long as they are marked personal and/or confidential.

With my permission, the office of ***Barry Goldman Physical Therapist PLLC*** may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that ***Barry Goldman Physical Therapist PLLC*** restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing ***Barry Goldman Physical Therapist PLLC*** to use and disclose my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____
Print Patient's Name

_____ _____
Signature of Patient or Legal Guardian Date

_____
Print Name of Patient or Legal Guardian