Greater Buffalo Physical Therapy
Hands on. It's What We Do

PATIENT NAME: ____

Dear Therapy Patient,

Therapy services are generally covered in whole, or in part, by most insurance carriers. It is each patient's responsibility to check with his or her insurance carrier to determine what limitations they set for therapy, such as, length of treatment or number of treatments allowed per year. *Please let our office staff know, if your injury is in any way related to a No-Fault or a Worker's Compensation case*.

Some companies have co-payments and deductibles as part of their policy. If treatment is denied due to a deductible, you will then be responsible for the portion not paid by your insurance.

If you have a co-payment, please remember that we require that you pay at the time of your appointment. *Please let us know at your first visit if you have a secondary insurance that you submit your co-payments to so that we may provide you with a full receipt. Our office does not do secondary billing*.

If your coverage runs out before your treatments are complete, you may choose to privately pay the remainder of your treatments. Special arrangements may be made regarding private payment.

We are making an effort to provide all of our patients with efficient quality care. We work on a scheduled basis; therefore, it is important that you attend your scheduled appointment and arrive on time. Please remember that progress in therapies requires constant attendance at treatment sessions.

Please contact Greater Buffalo Physical Therapy if you will be late for your therapy appointment or well in advance if you are unable to keep your scheduled appointment (24 hours is notice or there will be a charge to your insurance company).

Thank you for your cooperation. It will help us to serve you better.

Joseph E. Robinson ND, MS, ATC, PT – Owner

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I have read and understand this notice on behalf of myself, as the patient, or as a representative of the patient to whom it is addressed.

_____________________________________ ____________________________

Patient Signature Date

PATIENT INSURANCE INFORMATION

Name (Last, First, Middle): _____
Address: _____ City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Gender: _____ Date of Birth: _____ Social Security #: _____
Email Address: _____
Injured Area (Body Part) _____
Do you wish to receive appointment reminders? ◯ YES ◯ No ☐ text ☐ email ☐ phone
Referring Doctor's Name: _____ Phone: _____
Doctor's Address: _____

Employer: _____
Address: _____ Phone: _____
Are you currently working: _____

*Employment Related (Y/N): _____ *Auto Accident Related (Y/N): _____

Primary Insurance: _____
Policy #: _____ Suffix: _____ Group #: _____
Insured Person: _____ DOB: _____ Gender: _____
Relationship to Patient to Insured: ____ Self _____ Spouse _____ Child _____ Other
Student: _____ Full Time _____ Part Time
Married: _____ No _____ Yes

Assign and Release: I hereby authorize payment of medical benefits to this provider for all my services. I also authorize the release of any information necessary to process my claims. I also realize that it is my responsibility to pay for any balance that is not covered by my insurance.

I have read the above statement and understand my responsibility for payment of services rendered.

Patient Signature: _____

**If Workman's Comp or No Fault covered treatment, please complete:*

Workman's Comp Case #/No Fault Case#: _____
Location of accident: _____ Date of accident _____
How it happened: _____
Insurance Carrier: _____ Handler's Name: _____
Address: _____ Phone: _____

FINANCIAL POLICY AND MEDICAL RELEASE FOR PATIENTS WITH COMPENSATION, NO FAULT OR PARTICIPATING INSURANCE

All services will be billed to responsible insurance companies. If for any reason the claim is rejected, *you will be responsible for payment*. On past due accounts, a monthly billing fee may be added.

Any required co-payment is due on the day of the visit.

After the insurance payment is received, any deductibles that are the patient's responsibility are due immediately upon receipt of a bill.

There is a $25.00 fee for appointments that are REPEATEDLY not cancelled prior to the 24 hours of a scheduled appointment.

There will be a $10.00 service charge for insurance forms that require someone in our office to complete.

The parent who brings a child for care is responsible for payment regardless of personal circumstances.

I further give authorization to release and obtain any information pertinent to my case.

I authorize payment directly to Greater Buffalo Physical Therapy for medical benefits, if any, otherwise payable to me under the terms of my insurance.

I have read, and will cooperate with this financial policy.

Signed: _____

Date: _____

Witness: _____

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1. Present complaint: _____
   _____
   _____

2. When did your problem begin? (specific date if possible): _____
   _____
   _____

3. How did you injure yourself? _____
   _____
   _____

4. How often are the complaints present?
   ____ Constant (76-100%) ____ Frequent (51-75%)
   ____ Occasional (26-50%) ____ Intermittent (25% or less)

5. How bad is your pain? Please circle a number

   0 1 2 3 4 5 6 7 8 9 10

   No pain unbearable pain

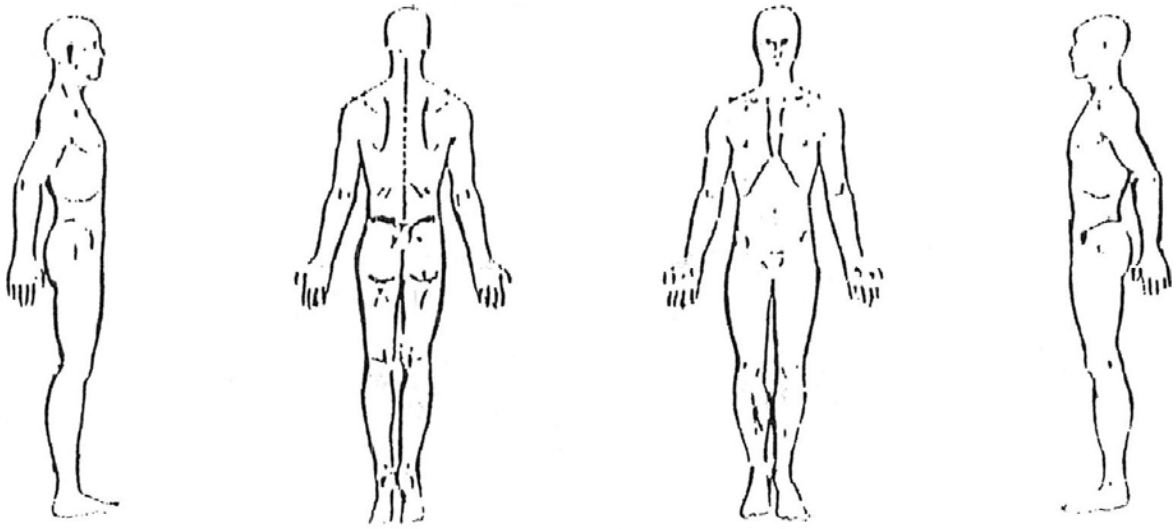
6. Since your problem began, is the pain
   ____ increasing ____ decreasing ____not changing

7. What treatments/tests have you received for this present condition?
   ____ None ____ Previous Physical Therapy ____ Surgery
   ____ Chiropractic ____ Medications ____ X-ray, MRI, CT Scan
   ____ Other _____

8. What makes your problem better? ___ Nothing ____ Rest ____ Lying Down
   ____ Walking ____ Standing ____ Sitting ____ Movement/Exercise

9. What makes your problem worse? ___ Nothing____ Rest ____ Lying Down
   ____ Walking ____ Standing ____ Sitting ____ Movement/Exercise

Please mark an X on the picture where you have pain or other symptoms. Include symptoms of pain, numbness or tingling.



10. How is your problem affecting your ability to work, be active, or sleep?

_____

_____

11. Physical activity level at work?

____ Mostly sitting ____ Light manual labor

____ Moderate manual labor ____ Heavy manual labor

12. General physical activity level? ____ No regular exercise program

____ Light exercise program ____ Strenuous exercise program

Please check any of the following that apply to you:

____ Diabetes
____ Arthritis
____ Kidney Disorders
____ Allergies
____ Loss of bladder/bowel control
____ Fainting, visual disturbances
____ Nausea
____ Convulsions
____ Dizziness
____ Headaches
____ Depression
____ High Blood Pressure
____ Angina
____ Heart attack
____ Stroke
____ Cancer
____ Prostate problems
____ Drug or Alcohol Dependence

Please list any previous surgeries: _____
_____
_____

Please list your medications: _____
_____
_____

Is your case in current litigation? ____ Yes ____ No

Are you pregnant? ____ Yes ____No

How did you hear about us? _____
_____
_____

What are your goals for physical therapy? _____
_____
_____

Patient signature _____ Date: _____

Dear Patient:

It is necessary for us to have written consent in your medical file if you want us to be able to communicate any medical information about yourself to another individual. If you want us to release information to a family member, such as a spouse, a significant other, a parent or a sibling, you must indicate the name of that specific person(s). WE WILL BE UNABLE TO RELEASE ANY INFORMATION TO ANYONE OTHER THAN WHO IS INDICATED ON THIS FORM.

I, _____, herby give my permission for the staff of Greater Buffalo Physical Therapy to release medical information about myself to:

_____

(Name of person you are authorizing) (Relationship)

_____

(Name of person you are authorizing) (Relationship)

I can cancel this authorization at any time in writing.

Signature _____

Date Signed _____

If you do not want to authorize the release of medical information to any individual, please sign below.

I, _____, decline to have any medical information in regards to myself released to any individual.

Signature _____

Date Signed _____

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

I, _____, understand that as part of my health care, Greater Buffalo 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 read or 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 Greater Buffalo Physical Therapy is not required to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, the organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Greater Buffalo 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 Greater Buffalo Physical Therapy change their notice, they post the most current notice in their facilities. In addition, each time you visit our facilities for treatment, you may obtain a copy of the current notice in effect upon request.

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 by 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 _____

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