Please review, edit or complete *(USING BLACK INK ONLY)* all information below.

Name:	**Date of Birth:**

Address:	**City/State/Zip:**
Primary Phone:	**This is your:** ❑ Home ❑Cell ❑ Work
Secondary Phone:	**This is your:** ❑ Home ❑Cell ❑ Work
Email Address:	**Social Security #:**

Emergency Contact:	**Relationship:**	**Contact Phone #:**
Emergency Contact:	**Relationship:**	**Contact Phone #:**

*** We do not call to remind you of your appointments this service is available by text or email only***

❑ **Yes! I would like appointment reminders sent to me:**

Email me at: ______________________________

Text me at: (_____)____________________ **Cell phone Carrier:**____________________

I Authorize Mary Lou Corcoran Physical & Aquatic Therapy, PC to discuss my medical information with the following:

Spouse:	Phone #:
Family Member:	Phone #:
Referring Doctor:	Phone #:
Doctor other than Referring/Primary Care:	Phone #:
Attorney:	Phone #:
Other (relationship):	
I authorize MLCPT to leave a message regarding ***my physical therapy*** on my answering machine/voicemail. ❑ YES ❑ NO	
I authorize MLCPT to leave a message regarding ***my appointments*** on my answering machine/voicemail. ❑ YES ❑ NO	

Patient name: ____ **Date**____/____/_____

Reason (s) for attending physical therapy:	**Date of Onset:** **Date of Surgery:**
Primary Care Doctor: **Date of last appointment:**	**Referring Doctor**: **Date of Next Dr Appointment**:

Are you taking any medications now? ❑YES ❑NO If YES please list below or attach list:

MEDICATION	REASON FOR TAKING MEDICATION

Height ________________ **Weight**________________

Do you have now, or have you ever had, any of the following conditions?
Please check all that apply.

CONDITION	YES	NO	CONDITION	YES	NO
Are you pregnant NOW?	❑	❑	Diabetes	❑	❑
Electronic implant (s)	❑	❑	Osteoporosis	❑	❑
Pacemaker	❑	❑	Osteoarthritis	❑	❑
Rheumatoid Arthritis	❑	❑	Heart problems	❑	❑
High blood pressure	❑	❑	Cancer	❑	❑
Asthma	❑	❑	Other (please explain):	❑	❑
Seizures	❑	❑			

How did you hear about MLCPT?

____

Are you **<u>currently</u>** receiving **chiropractic**, **occupational, physical or speech therapy**?
❑YES ❑NO

If ***YES, <u>where</u>*** and for what injury?

Last date of service:

Have you had any ***physical therapy, occupational therapy , or speech therapy*** anywhere ***<u>other than MLCPT this year</u>***?

❑YES ❑NO

If ***YES***, ***<u>where</u>*** did you receive this care?

Last date of service:

Type of insurance to be billed for this injury:

- ❑ **Private Insurance**
- ❑ **Workers Compensation**
- ❑ **No Fault**
- ❑ **Third Party** (***we do not participate with third party insurance, you will be responsible for billing them yourself)***

Date of Injury/accident:

If this is a ***No Fault*** or ***Workers' comp*** case have you had **PT for *this case* before**:

❑YES ❑NO

If ***yes***, where have you had **PT**:

Employer at time of injury:	**Employer address:**
	Phone number:
Adjuster name:	**Adjuster phone number:**

Office & Financial Policies

Appointments

- Appointments are available Monday - Friday 6:30am - 6:00pm. The front desk in the main office is available to schedule appointments from 6:15am - 5:45pm Monday - Friday.
- Appointments are not automatically scheduled and must be booked by the patient; there are no "standing appointments". To ensure you receive appointments that best fit into your schedule, book them at least 48 hours in advance.
- A print out of your scheduled appointments is available. As you are responsible for any missed appointment, we recommend you review & retain the printout of your scheduled appointments in the event of a scheduling error.
- Arrive 5 minutes early for each appointment. Upon arrival for your appointment, sign in at the front desk, make copay/coinsurance payment and schedule any additional appointments.

No Show/Cancellation Policy

- If you fail to make your scheduled appointment and do not notify our office 12 hours prior to the scheduled time of your appointment, you will be charged a fee of $25.00 per missed appointment. This fee must be paid prior to the start of the next appointment. We reserve the right to charge you for overly missed appointments. Overly missed appointment includes No show, and Cancelled appointments with or without notice. A patient who misses three (3) appointments may be discharged

Prescriptions

- Prescriptions expire one (1) month from the date they were written. Patients are responsible for maintaining a valid prescription & for requesting an updated prescription from their doctor every thirty (30) days. The patient will be responsible for any visits not covered by their insurance because a valid prescription was not obtained.
- Some insurance companies honor the New York State law of Direct Access. Under Direct Access a patient may seek physical therapy services without a doctors prescription for ten (10) visits or thirty (30) days, whichever comes first. Please speak with a front desk associate for additional information.

HIPAA

- MLCPT's HIPAA policy is posted in the waiting area, a copy of this policy is available upon request. MLCPT will make all reasonable attempts to follow HIPAA policy. Due to the open environment of the therapy area, therapy gym, sports performance center and therapeutic pool, I waive HIPAA liability in those areas of the office.

Evaluations/Re-Evaluations

- Any new diagnosis will be treated only after a thorough evaluation.
- After a lapse in therapy greater than 30 days, a patient will be evaluated as conditions change over time.
- Re-Evaluations are required by both insurance companies and doctors. They will be done every 30 days and submitted to the referring doctor and primary care if listed.

Copays/Insurance Benefits

- MLCPT provides patients with an outline of their insurance benefits. This information is provided as a courtesy and is based on the information provided by the patients insurance company's customer service representative. It is the patients responsibility to know their insurance benefits, including but not limited to copy/coinsurance, deductible, referrals and visit limits.
- **All copays and coinsurance payments are due at the time of each appointment. (If 3 appointment payments are due patient may not be seen until payment is made.)**
- **Any balance not paid at the time of service will be billed; any balance unpaid after thirty (30) days are subject to a finance charge. The patient may not be permitted to schedule appointments until balances over 30 days are paid in full.**
- The patient is responsible for notifying the front desk of any changes in insurance, address or phone numbers.

Patient or Guardian Agreement:

I authorize release of information requested by my insurance plan for payment.
I understand payment is due at the time of service and I am responsible for any balance due.
I agree to comply with the terms and conditions as outlined in the *Office & Financial Policies*.
I hereby acknowledge that I have been offered a copy of the HIPAA policies.

Office & Financial Policies Authorization :

I hereby assign all medical benefits, to which I am entitled, including Medicare, private insurance, major medical and any other plan to Mary Lou Corcoran Physical & Aquatic Therapy, PC (MLCPT). I understand I am responsible for providing all of my insurance information and notice of any changes to that information that may take place. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be consider as valid as an original.

Medicare beneficiaries are responsible for charges in excess of the $1960.00 physical therapy cap and will be asked to sign an ABN when their balance reaches $1700.00.

I understand that I am responsible for all charges whether or not paid by said insurance. I understand that MLCPT cannot estimate the level of reimbursement by my insurance carrier due to the number of plans and variety of contracts within each plan. We (MLCPT) recommend that you check with your own insurance company about reimbursement and the need for prior authorization before having Physical Therapy. I understand copay/coinsurance is due at the time of service and additional balances will be billed to me. I understand it is possible that my fee for service may be different than the copay/coinsurance amount provided to me a s courtesy by MLCPT. I understand that it is my responsibility to know the balance of my deductible (if applicable) and to notify MLCPT when that has been met and, until that time, I will be responsible for paying my copay/coinsurance at the time of service. I also agree to pay any and all attorneys and/or collection fees of a reasonable amount on the unpaid balance, if this account is referred to collection. I certify that the information given to me in applying for payment under title XVIII of Social Security Acct is correct. I hereby authorize said assignee to use or disclose all information necessary for treatment, obtaining payment and health care operations.

I certify all the information I have provided to MLCPT is accurate at this time.

I hereby authorize MLCPT to perform any medical treatment as deemed necessary under the New York State Physical Therapy Practice Act.

I have read and agree to the *Office & Financial Policies* above and understand I am responsible for keeping a copy of this information.

____ _________________
Signature of Patient («Client Full Name») or Guardian: Date

____ _________________
Print Name Front desk initials