PRIME FITNESS
PHYSICAL THERAPY
& REHABILITATION

2952 BRIGHTON 3RD STREET BROOKLYN NY 11235
Tel: 718-676-4112 Fax: 718-676-4134

CONFIDENTIAL NEW PATIENT QUESTIONNAIRE 112

LAST NAME_____ FIRST NAME_____

ADDRESS_____

CITY_____ STATE _____ ZIP _____

PHONE (_____)_____ E-MAIL _____

AGE_____ DATE OF BIRTH _____ SEX M___ F ___ SOC. SEC# _____-_____-_____

MARITUAL STATUS: S___ M___ D___ W___ SPOUSE'S NAME _____

PRIMARY CARE PHYSYCIAN: _____

ADDRESS:_____

TELEPHONE: (_____)_____ FAX:_____

Automobile or Pedestrian Accident ___YES ___ NO Date of Accident _____ State_____

On the Job/Work related Accident ___YES ___ NO Date of Accident _____ State_____

A Potential or Pending Lawsuit ___YES ___ NO Date of Accident _____ State_____

The following information must be completed by all patients

INSURED'S NAME _____ INSURED'S SS# _____-____-_____
PATIENTS RELATIONSHIP TO INSURED: ___SELF ___SPOUSE ___CHILD B
NAME OF INSURANCE COMPANY _____
ADDRESS_____ POLICY# _____

SECONDARY INSURANCE

INSURED'S NAME _____ INSURED'S SS# _____-____-_____
PATIENTS RELATIONSHIP TO INSURED: ___SELF ___SPOUSE ___CHILD
NAME OF INSURANCE COMPANY _____
ADDRESS_____ POLICY# _____

PLEASE ALLOW OUR FRONT DESK TO PHOTOCOPY YOUR INSURANCE CARD

OCCUPATION _____ EMPLOYER_____
ADRESS_____ CITY_____ STATE_____ ZIP_____
TELEPHONE NUMBER_____ FAX NUMBER _____

Please note: If you are a worker compensation or motor vehicle accident patient, and you have personal health insurance, we require that you supply us with the secondary information in the event that workers compensation or the motor vehicle insurance would deny your claim. If you choose not to provide your personal health carrier information, please be aware that you will be responsible for any outstanding balance that may arise from a denial. Initial_____

Patients signature_____ Date_____

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PHYSICAL THERAPY MEDICAL ASSIGNMENT OF BENEFITS & FINANCIAL POLICY

We at Prime Fitness Physical Therapy, PC are pleased to be a part of your rehabilitation experience and thank you for choosing us. We find that communication with our patients regarding our financial policy assists in providing the best service to you.

INSURANCE BILLING

We will gladly call your insurance company to identify what your benefit coverage is, however, please understand that insurance companies will not guarantee medical benefits over the phone. We can only use this information as an estimated guideline. Actual determination is made 4 to 8 weeks later, after we receive the written notification and/or payments on your claim. We strongly encourage you to contact your insurance company directly in order to understand your plan's coverage and limitations. Please be aware that we will only bill up to two (2) insurance companies (primary& secondary) for MEDICARE related claims and only use one (1) insurance company (primary) for all other claims, unless prior arrangements have been made with our Billing Department.

Your insurance company may require a current physical therapy prescription (prescriptions expire 30 days from the date they are written), a "Letter of Medical Necessity" written by your physician and/or pre-authorization directly from your physician for therapy services. It is your responsibility to obtain said documents. Non-compliance on your part with this procedure may result in services not being reimbursed by your insurance company. As such, you will be held liable for payments of PT services rendered.

PAYMENTS

All deductibles, co-pays, and cash pay estimated amounts are due at the time of service, unless other arrangements have been made with our facility. Cash pay patients may receive a discount on the date of service if payment is made in full.

Once we received all payments or notifications from your insurance company, we will present you with your final statement. Payment for any outstanding balance will be due after you receive your final statement. If we do not receive the payment, we may be forced to pursue legal collection proceedings. Please do not hesitate to ask us any questions or request a copy of your account balance. Once again, we appreciate your choose of PRIME FITNESS PHYSICAL THERAPY, P.C. By signing this form, I, the patient (or legal guardian of the patient), have read, understood, and agree

PATIENT/GUARDIAN SIGNATURE_____ DATE_____

PATIENT NAME _____

LEGAL GUARDIAN NAME (if patient is minor) _____

WITNESS SIGNATURE_____ DATE_____

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AUTHORIZATION FOR TREATMENT

Physical Therapy is a patient care service provided in response to a wide range of medical care needs of outpatient of all ages.

- To treat disease, injury and disability by evaluation examination, testing and use of rehabilitative procedures, manipulations, massages, exercise and physical agents including, but not limited to, mechanical devices, heat, cold, electricity and ultrasound in the aid of diagnosis and treatment
- To obtain for the information needed in the evaluations and treatment of patients dysfunctions
- To prevent or minimize residual physical injury or disability
- To aid the patient in achieving maximum potential within his or her capabilities
- To accelerate convalescence and reduce the length of the functional recovery

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PATIENT NAME _____

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATIONABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purpose that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practices, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you.
We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Use and Disclosures; Under the Law, we must make disclosures to you and when required by the Secretary of this Department of Health and Human Services to investigate or determine our compliance with the requirements of section 164.500.

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CONTINUATION

Other Permitted and Required Uses and Disclosures will be made with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken into action in reliance on the use or disclosure in the authorization.

Your Rights: Following is the statement of your rights with respect to your protected health information.

You have the right to Inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceedings, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care options. You may also request that any part of your protected health information does not get disclosed to family members or friends who may be involved in your care or notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply to.
Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to Prime Fitness Physical Therapy PC or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint.
We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our MAIN OFFICE (516-873-6100).

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices.

Print Name: _____ Signature: _____

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EXPLANATION OF MEDICARE BENEFITS

Prime Fitness Physical Therapy P.C. is a Medicare participating provider.
Medicare cap for outpatient physical therapy $1780
Reimbursement for physical therapy services is 80% of $1780 ($1424) of the Medicare allowed amount ($1780). The remaining 20% ($356) is the patient's responsibility.
If you have a secondary insurance, we will bill secondary or supplemental insurance as a courtesy. Please be aware that payment may be denied for services, as we are not contracted will all secondary insurances. If you do not have secondary or supplemental policy, payment is due after Medicare has processed your claim. Any amounts not covered by a secondary or supplemental policy will become the patient's responsibility.
Physician follow-up: Medicare requires patients to follow up with their referring physician every 30 days. It is the patient's responsibility to obtain a new prescription from your physician.
Home Health Aid (home attendant). Visiting nurse/home health physical therapy:
It is extremely important for you to inform us if you have any type of Home Health Services. Medicare will not pay for outpatient physical therapy services if your home health provider is billing their services under Medicare Part B and not under medical fee schedule.
Have you had any services this year by any Home Health agency? (please circle) YES/NO
___(please initial): If you claim that even though you have a home attendant, billing Medicare part B for outpatient PT services rendered to you is a still covered PT services.
___(please initial): and that you are willing to take full responsibility for the payment of such services should CMS deny payment for said services based of concurrent existence of home health services to you.
Outpatient Physical Therapy:
Have you had any type of outpatient physical therapy within the last year? (please circle) YES/NO
I understand and completely agree to the above information.

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PAYMENTS: All deductibles, co-pays, and cash pay estimated amounts are due at the time of service unless other arrangements have been made with our facility. Cash pay patients may receive a discount on the date of service if payment is made in full. Once we received all payments or notifications from your insurance company, we will present you with present you with your final statement. Payment for any outstanding balance will be due after you receive your final statement. If we do not receive the payment, we may be forced to pursue legal collection proceedings. Please do not hesitate to ask us any questions or request a copy of your account balance. Once again, we appreciate your choosing PRIME FITNESS PHYSICAL THERAPY, P.C.
By signing this form, I, the patient (or legal guardian of the patient), have read, understand, and agree that I am 100% responsible for all fees incurred here at PRIME FITNESS PHYSICAL THERAPY, P.C. that are not covered by my insurance company.

PATIENT/GUARDIAN SIGNATURE_____ DATE_____
PATIENT NAME _____
WITNESS SIGNATURE_____ DATE_____