HIGH LINE REHAB
PHYSICAL THERAPY

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Patient Intake Form

Name: _____ Date:_____

Address:_____
street city state zip

Home Phone: _____ **Mobile Phone:** _____ **Email:** _____

Sex: Male/Female Date of Birth: _____ SS#: _____

Emergency Contact:_____ Phone:_____
Relationship: _____

Referring Physician_____ Phone: _____

Employment Information
Employed F/T_____ Employed P/T_____ Student F/T_____ Student P/T_____
Not Employed_____ Self Employed_____ Retired_____ Active Military_____

Employer/School:_____

Address:_____
street city state zip

Primary insurance Information
Insurance Company: _____ Insured's Name: _____

Insurance Policy Number: _____ Insured's Date of Birth: _____

Insurance Group Number: _____ Insurance Phone: _____

Secondary insurance Information
Insurance Company: _____ Insured's Name: _____

Insurance Policy Number: _____ Insured's Date of Birth: _____

Insurance Group Number: _____ Insurance Phone: _____

Date of injury or onset of symptoms: _____

Are you seeking treatment as a result of a work-related injury? (Please Circle) Yes / No
Are you seeking treatment as a result of a car accident? (Please Circle) Yes / No
Are you involved in a lawsuit because of your injury or symptoms? (Please Circle) Yes / No

I authorize and request the above-named insurance company to pay benefits for services rendered. I authorize High Line Rehab PT to use, disclose, and release all medical information necessary to process my health insurance claims.

_____ _____
Patient Signature Date

WORKER'S COMPENSATION/AUTO ACCIDENT INTAKE FORM

Patient's Information

Appointment Date/Time:_____ Therapist:_____

Last Name: _____ First Name: _____ Diagnosis:_____

DOB:_____ Referring Physician:_____

Address:_____
street city state zip

Phone: _____ Email: _____

Insurance Information: Symptoms related to Worker's Compensation or Auto (Please Circle)

Primary Insurance: _____

Policy Holder's Name: _____ DOB:_____

Member ID: _____ Group Number:_____

Worker's Compensation / Auto Accident:

Name of Insurance (Patient's PIP carrier for Auto **OR** Employer's Insurance Carrier for Worker's Compensation)

Claim Number: _____ Date of Accident:_____

Adjuster's Name:_____ Adjuster Phone Number:_____

Employer (for W/C only): _____ Company Number:_____

Claims Address:_____
street city state zip

Are you being represented by an attorney? **Y / N** Name: _____ Phone:_____

Is Authorization required (for W/C)? **Y / N** From:_____ To:_____ Auth #:_____

Apprvd DX:_____ Is PIP and/or MedPay available (for Auto Accidents) **Y / N** Amount?_____

I understand the benefits as quoted by my insurance company. Benefits are not a guarantee of payment. All claims are subject to review and medical necessity.

_____ _____
Patient's Signature Date

After receiving and reading High Line Rehab PT PC Notice of Privacy Practices, please acknowledge below:

Acknowledgment of Receipt of Notice of Privacy Practices

Patient Name: _____ **DOB:** _____

By signing below, I acknowledge that I have received the High Line Rehab PT Notice of Privacy Practices.

_____ _____

Signature of Patient or Legal Representative **Date**

The privacy, security, and confidentiality of your health information are important to us. Please let us know how you prefer us to contact you with results, questions, or appointment reminders.

Please select and number in the order we should attempt: (Please Check)

___ Home Phone – Can we leave a message? ___ yes ____no Phone Number: _____

___ Mobile Phone– Can we leave a message? ___ yes ____no Phone Number: _____

___ Work Phone – Can we leave a message? ___ yes ____no Phone Number: _____

___ Email: _____

___ Mail to Home Address: _____

___ Telephone/Message to another person—Name: _____ Phone Number: _____

Please list any other persons to whom we may discuss your healthcare treatment and/or payment information. Many patients take this opportunity to list a spouse and/or an adult, child or caregiver who often participates in their healthcare decisions and payment.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

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Medical Screening Form

It is important to gather information about your medical history in order to provide you with the highest quality care. Please fill out this form to the best of your knowledge. Thank you!

The information was completed accurately and to the best of my knowledge.

Name: _____

Please check (√) if you or a family member (&whom) has had the below conditions……

Osteoarthritis?	_____	Heart Disease?	_____	Rheumatoid Arthritis?	_____
Diabetes?	_____	Stroke?	_____	Angina/Chest Pain?	_____
Cancer?	_____	Osteoporosis?	_____	High Blood Pressure	_____
Allergies?	_____	Skin Disease/ Rash?	_____	Asthma?	_____
Broken Bones/ Fractures?	_____	Blood Disorder?	_____	Lung Problems?	_____
Circulation/ Vascular Issues?	_____	Muscular Dystrophy?	_____	Head Injury	_____
Low/ High Blood Sugar?	_____	Thyroid Problems?	_____	Depression?	_____
Multiple Sclerosis?	_____	Kidney Problems?	_____	Addiction?	_____
Seizures/Epilepsy?	_____	Neurological Disorder?	_____	STD?	_____
Ulcers/ Stomach Problems?	_____	Infectious Disease?	_____	Liver Problems?	_____

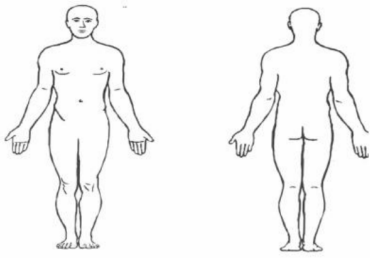
In the last 6 months have you experienced…

An overall health change?	_____	Chest Pain/Angina?	_____	Cough?	_____
Shortness of Breath?	_____	Dizziness/ Fainting?	_____	Weakness?	_____
Coordination Problems?	_____	Balance Problems?	_____	Fatigue?	_____
Fever/Chills/Night Sweats?	_____	Nausea or Vomiting?	_____	Headaches?	_____
Numbness or Tingling?	_____	Trouble Sleeping?	_____	Hearing Issues?	_____
Change in Bowel or Bladder?	_____	Weight Loss or Gian?	_____	Vision Problems?	_____

Are you currently… Under Stress? Depressed? Pregnant?

Illnesses that you have had in the past year: _____
Previous Surgeries (Please include dates): _____
Current Medications/Vitamins/Supplements: _____
Date of Last Physical and Name of Physician: _____

Fill in the area of concern:



Scale: 0 is no pain and 10 is worse pain
Pain at worse _____
Pain at rest_____

Functional Activities:

Please circle the activities listed below that you perform with difficulty or discomfort as a result of your injury.

Kneeling Sleeping Balance Feeling Stairs Squatting Bending Walking Pulling Carrying Pushing Standing Grasping Reaching Crawling Handling Sitting Working Reading Computer Lifting Cough/Sneeze

Grooming/Activities of Daily Living/Housework:

Brushing Teeth Pulling on Shirt Shoes/Socks Using Toilet Bathing Shaving Driving Trousers/Pants Lifting Vacuuming Laundry Cleaning Tub Making beds Washing Dishes Cooking Sweeping Scrubbing Floor Mopping Grocery Shopping Sex

Recreational Activities:

Jogging Hiking Bicycling Walking Golfing Skiing Aerobics Swimming Movies

_____ Patient's Signature

_____ Date

FINANCIAL POLICY: Please read and initial below.

Our Financial Policy is designed to promote due diligence and provide a proactive rather than reactive strategy. With your participation, this policy will minimize and potentially eliminate errors and miscommunication with regard to your insurance or other financial arrangement for payment. We will not become involved in disputes between you and your insurance company regarding, but not limited to; deductible, co-insurance, co-payments, covered services, pre-authorization, and usual and customary charges.

_____ **REVIEW YOUR BENEFITS** We urge you to review your insurance policy. Your insurance policy is a contract between you and your insurance company. Please call your insurance company with any specific questions about your policy relating to outpatient physical therapy benefits. You need to accurately verify and understand your policy's deductible, co-payment, coinsurance, visit limitation, effective annual calendar renewal date, and any pre-authorization requirements. As a courtesy, we will verify your coverage, but we will not guarantee the accuracy of the information we receive. You are responsible to know your level of coverage and you are ultimately responsible for the full payment. If you have secondary insurance, you must present it at your initial visit. The same policies and responsibilities apply to the use of secondary insurance. You are responsible for the accuracy of the insurance information we use to submit the claim, and you are ultimately responsible for the full payment of your bill.

IN-NETWORK You are responsible for meeting the in-network deductible before your insurance will begin to reimburse for **the services rendered. You are responsible for co-payment/coinsurance as specified in your "schedule of benefits". High Line Rehab PT PC has agreed with your insurance company to accept the in network or preferred provider maximum allowable charge** as full payment for the services rendered. There will be no balance billing for covered services. You are responsible to pay for any services or supplies that are received but not covered under your policy. Co-pays or deductibles are due at the time of service.

_____ **OUT-OF-NETWORK** PhysioCare Rehab & Wellness may be out of network with your insurance and **High Line Rehab PT PC will notify you of our network participation. If your policy has out of network benefits available, we will accept your** insurance, and work with you on deductibles, coinsurance, and limitations. You are still responsible for meeting patient responsibility **or upholding the agreement made between you and High Line Rehab PT. You will still be responsible for deductible, co-** payments and/or coinsurance at each time of service. Your out-of-network benefits for outpatient physical therapy will be clearly explained in your insurance policy's "schedule of benefits". We will submit claims for payment to your insurance company.

_____ **NON-INSURANCE CASH PLANS** (Self-Pay) Cash plans are exclusively a non-insurance financial agreement. Cash arrangements are exclusively separate from the In-Network and Out-Network scenarios. Cash plan receipts cannot be submitted to **insurance for reimbursement. High Line Rehab PT offers a cash plan based on an insurance fee schedule and is for pat ients** who have exhausted benefits during treatment, and those who wish to participate in therapist supervised injury prevention programs. Payment must be received for the services at the time of service, in full.

MOTOR VEHICLE ACCIDENT AND WORKER'S COMPENSATION PATIENTS

High Line Rehab PT does not accept third party payments. In the event you are seeking treatment for injuries sustained in a car accident, you must either use and exhaust your medical payments coverage (if applicable) or use your primary health insurance. If neither of these applies to you, we require that you obtain an attorney to ensure your claims are paid. Worker's Compensation claims should be filed and approved by your employer/worker's compensation insurance carrier **BEFORE** you receive services from High Line Rehab PT

_____ **PAYMENT** We accept cash, check, and all major credit cards. There will be a $25 service charge for all your returned checks. If you have insurance, balances will be considered current from the date you receive service. Patients will receive a statement every 30 days if applicable. Please ask us if you need to set-up a customized payment plan.

_____ **APPOINTMENT POLICY** **High Line Rehab PT understands that many of our patients have very busy schedules.** Our schedule is very flexible to accommodate our patient's needs. We do understand that situations do occur that we cannot control or plan for. If you do need to cancel your appointment, please give a minimum of 12 hour notice. A cancellation fee of $25.00 will apply to the 2nd cancellation without a 12 hours' notice. You must notify our office of a cancellation of your appointment by phone or email or your missed appointment will be considered a NO SHOW. Each appointment that is marked as a no show will be subject to a $25.00 charge on the first offense. A patient's refusal to initial does not exempt them from this policy. This policy applies to every **patient that is seen at High Line Rehab PT. This charge is not covered by Workman's Co mpensation or by insurance companies. It will be the responsibility of the patient to pay this charge.**

Thank you for giving us the opportunity to serve you, and please feel free to ask us any questions concerning our services, policies and fees.

The undersigned accepts ultimate financial responsibility for services rendered.

_____ _____

Responsible Party Signature Date

Notice of Privacy Practices (HIPAA)

In accordance with HIPPA privacy regulations, we are notifying you as to how medical/protected health information about you may be used and disclosed. Under the law, we are required to maintain the privacy of this information, but may need to share protected health information (PHI) to others in order to process your claims or for health care operations, which may include but are not limited to: 1) Receive Payment 2) Verify Insurance 3) Conduct quality assessment 4) Care Co-ordination/Management, 5) Manage our Business 6) Assist other covered entities with their health or business operations 7)Accreditation, Certification, Social Services 8) Disclosure to the Secretary of the United States Department of Health & Social Services 9) Health Oversight Agencies 10) To prevent a serious threat to Health or Safety 11) Research 12) Workman's Compensation 13) Public Health & Safety 14) Legal, National Security or Law Enforcement 15) Personal Physician, Team Physician, Athletic Director or Coach 16) To you or your designee upon written request 17) Other uses and disclosures of PHI only after written authorization.

All evaluations, Progress Notes, as well as significant changes in Medical conditions will be reported via fax, phone and/or mail to your referring Physician and possibly Primary Care Physician. All insurances will be verified with pertinent PHI being released to the insurance company(s) necessary to process claims. All patients will be asked to sign in at the front desk upon arrival and names will be announced.
Part of the treatment is performed in an open environment. Some claims are billed electronically. If you wish not to sign in on the sign in sheet, not to be in an open environment, not to have your name announced, not to have your insurance company billed electronically please notify the receptionist immediately and we will attempt to make the alterations to accommodate your needs. If you have any questions, please ask to speak with the clinical director.

_____	_____	_____
Signature of Patient/Guardian	Date	Relationship to Patient