Cross Bay Physical Medicine & Rehabilitation, P.C.

Cross Bay Foot Care Center

Cross Bay Physical Therapy

157-02 Crossbay Blvd, Suite 202 Howard Beach, NY 11414 P: (718) 835-0100, F: (718) 848-2233

Today's date: **(Please Print Clearly)**

PATIENT INFORMATION

Last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
E-mail :	SSN #:	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address: Apt.#	Home ph.# ( )	Cell ph#( )			
P.O. box:	City:	State:	ZIP Code:		
Occupation:	Employer:	Employer ph# ( )			

Current Work Status: ❑ Full Time ❑ Part time ❑ Full time w/Limitations ❑ Part time w/Limitations ❑ Not Currently Employed ❑ Retired ❑ Disability

Race: (please Check one) ❑ American Indian ❑ Asian ❑ Black or African American ❑ Chinese ❑ Hispanic ❑ Other Pacific Island ❑White ❑ Other _____

Ethnicity: (please Check one) ❑ African ❑ Asian ❑ Chinese ❑ Caucasian ❑French ❑German ❑Hispanic / Latino ❑Irish ❑Jewish ❑ Italian❑Polish ❑ Russian ❑ Other

Primary Language: (please Check one) ❑ English ❑ Spanish ❑ French ❑Italian ❑German ❑Russian ❑Chinese ❑Japanese ❑ Other _____

***Whom may we thank for referring you?** ❑ doctors office , if so what Dr: _____ ❑ friend/family
❑ Insurance company ❑ internet ❑ law office _____ ❑ other: _____

Primary Care Physician: Name: _____Last time seen: _____

Address/ Phone: _____

Pharmacy Information: (We send your prescriptions directly to your pharmacy so there is less waiting time for you.)

Name: _____Phone: _____

Address: _____ State: _____ Zip: _____

Emergency Contact: Name: _____ Relationship: _____

Phone: _____ Work Phone: _____Email:_____

I Certify that all the above and below information is correct.

_____	_____	_____	_____
Print Name	Signature of Patient or Responsible party	Relationship to Beneficiary	Date

entered by_____reviewed by_____Date:_____

Updated: 1/15

Insurance Certification

It is the patient's responsibility to inform the office about any changes in your insurance, address or telephone number. You are responsible to bring all appropriate insurance referrals & authorizations, if such required. **Failure to do so will result in financial responsibility for the services provided.**

Insurance assignment and release

I certify that I have insurance coverage with _____ and assign directly to Dr**. Benjamin Bieber / Dr. Debra Weinstock / Cross Bay Physical Therapy** (circle one) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services

MEDICARE/MEDICAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits be made on my behalf to **Dr. Benjamin Bieber / Dr. Debra Weinstock / Cross Bay Physical Therapy** (circle one) for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medicap insurer and their agents any information needed to determine these benefits for related services.

Patient Name (print name): _____ Date: _____

Signature: _____ Date: _____

patient or responsible party

entered by_____reviewed by_____Date:_____ *Updated: 1/15*

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Confidential MEDICAL HISTORY FORM

Chief Complaint: _____

History of Chief Complaint: _____

Severity of Pain: (circle) 1 (No pain) 2 3 4 5 6 7 8 9 10 (Most Severe)

How long have you had your pain: _____

Have you had any of the following treatments? ☐Injections ☐Physical therapy ☐Braces / Supports

***What does your "chief complaint" prevent you from doing that is important to you?**: _____

_____

Is this visit due to a work-related injury? ☐ Yes ☐ No **Is this visit related to a car accident?** ☐ Yes ☐ No

What Medications have you previously taken for this pain (include over the counter medication: advil, motrin, aleve, etc.)

_____

List any allergies you have to drugs, food or other items:

Allergy _____ **Reaction** _____

_____ _____

List the medications you are now taking below: *****If you have a list please give to front desk or medical assistant

Current Medications	Dose	Frequency

Please list all operations:

Operations Performed Year Hospital Doctor

_____

_____

Vital Signs by History:

Blood Pressure _____ Date _____
Height _____ Date _____
Weight _____ Date _____

Have you had any recent X-rays, MRI's or Cat Scans?

❑ X-ray _____ Date: _____
❑ MRI _____ Date: _____
❑ Cat Scans _____ Date: _____

entered by_____reviewed by_____Date:_____

Updated: 1/15

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Prescription Agreement Form

The purpose of this agreement is to protect your access to controlled substances and protect our ability to prescribe for you.

The long- term use of such substances as opioids (narcotics, analgesics), benzodiazepine tranquilizers and barbiturate sedatives is controversial because of uncertainty regarding, the extent to which they provide-long term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of the risk is not certain. Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the physician whose signature appears below to consider the initial or continued prescription of a controlled substance to treat your chronic pain.

1. All controlled substances must come from the physician whose signature appears below or, during his or her absence, by the covering physician, unless specific authorization is obtained for an exception. (Multiple sources can lead to untoward drug interactions or poor coordination of treatment.)
2. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is:

***_____ Phone: _____**

3. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.
4. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacist or other professionals who provide your health care for purposes of maintaining accountability.
5. You may not share, sell or otherwise permit others to have access to these medications.
6. These drugs should not be stopped abruptly, as an abstinence syndrome will likely develop.
7. Unannounced urine or serum toxicology screens may be requested, and your cooperation is required. Presence of unauthorized substances may prompt referral for assessment for addictive disorder.
8. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or other wise have access to them.

X_____ Date_____

Signature of patient or responsible party

entered by_____reviewed by_____Date:_____ *Updated: 1/15*

Confidential MEDICAL HISTORY FORM (continued)

Which of the following conditions are you currently being treated or have been treated for in the past (please check)

☐Heart disease / Murmur / Angina	☐Numbness/Tingling	☐Liver problems	☐Cancer
☐ High blood pressure	☐Radiculopathy	☐Hepatitis	☐ HIV/Aids
☐High Cholesterol	☐Neuritis/Neuroma	☐Lung problems	☐Thyroid
☐Palpations/Pacemaker	☐Stroke	☐Sinus problems	☐ Allergies
☐Poor circulation/Vascular disease	☐Paralysis	☐Shortness of breathe	☐Tuberculosis
☐Anemia or blood problems	☐Spinal stenosis	☐Asthma	☐Bowel Disease
☐Phlebitis	☐Fibromyalgia	☐Emphysema	☐Diverticulosis
☐Heart attack	☐Gout	☐Pancreas Problems	☐Prostate
☐Congestive heart failure	☐Lupus	☐Colitis	☐ Colitis
☐Falling / History of a fall	☐Lyme disease	☐ Current Weight Gain/Loss	☐ GI upset/heartburn
☐Walks with a cane or walker	☐Polymyalgia rheumatica	☐Swollen ankles	☐Ulcer stomach
☐Joint Pain _____	☐Raynaud's syndrome	☐ Swelling	☐Kidney problem
☐Joint Aches/Locking _____	☐Scleroderma	☐ Blurred Vision	☐Bladder
☐Arthritis	☐Sojourn's disease	☐Eye disorder / Glaucoma	☐Cancer
☐Unstable walking	☐ Psoriasis	☐Nose problems	☐Abdominal pain
☐Weakness	☐Diabetes	☐ Psychiatric Care	☐Seizures
☐Malaise	☐Athletes foot	☐Irritability/Mood Change	☐Recent Fever
☐Stiffness	☐Dermatitis	☐Sleep Disturbance	☐Headaches
☐Pins and Needles/Numbness	☐Bruises	☐Sweating	☐
☐Neuropathy	☐fungus nails		
☐Neurologic problems	☐Ulcers- skin	☐Dizziness	

☐OTHER serious Illness _____

Is there any Family History of the above conditions? If so, please list with family member who has or had the condition:

_____

_____

_____

Social History:

Do you smoke? ☐Yes ☐No If yes, how many packs per day: _____ How many Years? _____

Treatment Consent:

I hereby consent and give my permission to the doctor (doctor's assistant or designated replacement) to administer and perform procedures upon me as the doctor deems necessary.

SIGNATURE: X_____DATE: _____

entered by_____reviewed by_____Date:_____

Updated: 1/15

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PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of Practice's *Notice of Privacy Practices*:

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

_____ _____ X_____ _____

Name of Patient **Date of Birth** **Signature of Patient/Parent/Guardian** **Date**

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain pieces of my health information to a Personal Representative of my choosing, since such person is involved with my healthcare or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my health care.

Print Name:_____ **Last four digits of SSN or other identifier:**_____
Print Name:_____ **Last four digits of SSN or other identifier:**_____
Print Name:_____ **Last four digits of SSN or other identifier:**_____

III. Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home Telephone Number:

_____
____ OK to leave message with detailed information
____ Leave message with call back numbers only

Written Communication Address:

_____
____ OK to mail to address listed above
____ E-mail me at:_____

Work Telephone Number:

_____
____ OK to leave message with detailed information
____ Leave message with call back numbers only

Fax Communication:

_____
____ OK to Fax at the number listed above
____ E-mail me at:_____

Other:_____

IV. The following person(s) <u>are not authorized</u> to receive my Patient Health Information (PHI):

Print Name:_____ **Print Name:**_____
Print Name:_____ **Print Name:**_____

1. The above authorizations are voluntary and I may refuse to agree to their terms without affecting any of my rights to receive healthcare at the Practice.
2. These Authorizations may be revoked at any time by notifying the Practice in writing at the Practices mailing address marked to the attention of "HIPAA Compliance Officer."
3. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.
4. I may see and copy the information described in this form, if I ask for it, and I will get a copy of this form after I sign it.
5. This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction, that I fully understand this authorization form, and have received an executed copy.
6. This authorization is valid as of the date I have signed below and shall remain valid until changed or revoked.

Name of Patient (Print) Signature of Patient Date

entered by_____reviewed by_____Date:_____ *Updated: 1/15*

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FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

REGARDING INSURANCE:
We accept assignment of insurance under most plans. We cannot bill your insurance unless you give us your insurance information and an original claim form if necessary. Your insurance policy is a contract between you and your insurance company. We are not party to the contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services or not considered reasonable and necessary under the Medicare Program and/ or other medical insurance. The balance due is your responsibility whether your insurance company pays or not.

REGARDING REFERRALS:
It is your responsibility to obtain all referral forms required by your insurance company. Please be aware that if you choose to be seen by our doctor under an out of network insurance plan, you assume liability for the difference in coverage benefits.

COPAYS:
You will be expected to pay your copay at the time of your appointment. If you are unable to pay, you will be required to reschedule your appointment. We accept cash, checks, money orders, Visa, MasterCard and Discover.

USUAL AND CUSTOMARY RATES:
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

REGARDING PATIENTS WITH NO INSURANCE:
Payment is due at the time of service.

REGARDING PATIENTS WITH MEDICARE:
We will file all charges with Medicare and your supplemental insurance if applicable. If you do not have supplemental insurance, you are expected to pay for the 20% not paid by Medicare, or any deductible that has not been met at the time of your appointment.

MINOR PATIENTS:
Patients under the age of 18 **must** have a parent and/or guardian accompany them to our office before treatment can be rendered. The accompanying adult of minor and /or the parents (or guardians of the minor) are responsible for full payment.

MISSED APPOINTMENTS:
We require that you call at least 24 hours in advance. Appointments that are missed will accrue a fee of $50.00 that will be charged to the patient's account.

It is always your responsibility to be sure that your account is settled.

I hereby authorize the release of any information necessary to file a claim with my insurance company and assign benefits to Benjamin Bieber, MD / Debra Weinstock, DPM / Cross Bay Physical Therapy.

I acknowledge that I have read the billing policies listed above, agree, and understand my responsibilities as a patient at Benjamin Bieber, MD / Debra Weinstock, DPM / Cross Bay Physical Therapy. I also understand that if I fail to pay charges, I imply discontinuation of medical services.

_____ _____

Signature (patient or responsible party) Date

entered by_____reviewed by_____Date:_____

Updated: 1/15