PARK Physical Therapy

Raymond N. Cecora, P.T., D.P.T., M.S.
Nicole J. Brock, D.P.T.
Travis Tennie, D.P.T.
John "Jack" Bianchini, D.P.T.
Louis Mastrangelo, P.T.A
Joseph Cannisi PT, DPT, ATC, CSCS

## Patient Information Sheet

Name_____ Date of Birth_____
Address_____ City_____ Zip_____
Home Ph# (___)_____-_____ Cell Ph#(___)_____-_____ Email _____

**You will be receiving a reminder of your appointments. Please provide your preferred method of receiving these reminders. Please CIRCLE ONLY ONE: Home Cell Email**

Emergency Contact_____ Ph#(___)_____-_____
Relationship with Contact_____ Marital Status_____

**PRIMARY CARE DR**_____ **REFERRING DR**_____
Who can we thank for referring you? Physician? _____ Friend _____ Other _____

**HAVE YOU RECEIVED PHYSICAL THERAPY AT ANOTHER FACILITY IN THE PAST YEAR? YES / NO**
**If yes: Name & Location**_____

**INSURANCE**
**Primary**_____ Name of Insured_____
Date of Birth_____ Relationship: self_____spouse_____child_____
Social Security #_____ Employer_____ Ph#(___)_____-_____
**Secondary**_____ Name of Insured_____
Date of Birth_____ Relationship: self_____spouse_____child_____
Social Security #_____ Employer_____ Ph#(___)_____-_____

**Worker's Compensation / No- Fault**
Date of Accident_____ Insurance Carrier_____
Claim#_____ Contact Person_____ Ph#(___)_____-_____

I hereby authorize payment of medical benefits to Raymond N Cecora, P.T., D.P.T., M.S., C.E.A.S. for services rendered by him in person or a licensed physical therapist or a physical therapist assistant employed by him. I understand that I am financially responsible for any balance not covered by my insurance. I certify that the information given by me in applying for payment is correct. I authorize all records on request. I request all authorized benefit payments be made on my behalf.

***NO FAULT*: Have you completed your No-Fault Application? YES / NO**

**PLEASE NOTE: IF YOU DO NOT HAVE A REFERRAL FROM YOUR PHYSICIAN, PODIATRIST, NURSE PRACTITIONER, DENTIST; OR YOU HAVE BEEN RECEIVING HOMECARE, OR YOU ARE NOT FAULT PATIENT WITH AN INCOMPLETE APPLICATION -- YOUR PHYSICAL THERAPY VISITS MAY NOT BE COVERED BY INSURANCE AND THEREFORE THE PATIENT'S RESPONSIBILITY.**

**Patient Signature**_____ Date_____

**Parent/ Guardian Signature**_____ Date_____

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**Personal History Form**

Name_____ Date _____

Date of Onset for Current Symptoms _____

**Please List:**

Past Medical History _____

_____

_____

Past Surgical History and Date _____

_____

_____

Do you have a Pacemaker, Defibrillator? _____

Are you currently pregnant or trying? YES NO

Medical Testing (MRI, CT Scan, X-Rays) -- **Please Include Where and When Test Was Completed*

_____

_____

History of Falls _____

Medications / Prescriptions _____

_____

_____

Over the Counter Medications _____

_____

_____

Phone# (516)798-3789 5500 Merrick Road, Massapequa, NY 11758 Fax# (516)798-3589

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**Authorization Form**

I, _____, hereby authorize Park Physical Therapy to use and or disclose in protected health information pursuant to the Notice of Privacy Practice are posted in this office. I have been given the opportunity to review and or receive a copy of these privacy practices.

This authorization shall be in force and effect until such time that I give notification requesting the termination of this authorization.

I understand that I have the right to evoke this authorization in writing at any time by sending such written notification to the attention of Linda Cecora, Privacy Officer at 5500 Merrick Road, Massapequa NY, 11758. I understand that a revocation is not effective to the extent that Park Physical Therapy relied on the use of disclosure of the protected health information.

I understand that I have a right to:

Inspect or copy the protected health information to be used or disclosed as permitted under federal or state law to extent the state law provides greater access rights and/or refuse to sign this authorization.

_____ _____
Signature of Patient or Personal Representative Date

_____
Name of Patient or Personal Representative

Person(s) we can discuss your care with other than your Referring Physician including spouse, significant other, and children:

_____
_____

Can we leave a voicemail on answering machine at home? YES or NO
Can we leave a voicemail on answering machine at work? YES or NO
Can we leave a voicemail on answering machine at cell? YES or NO

**THIS AUTHORIZATION IS BEING REQUESTED BASED ON THE NEW FEDERA; REGULATIONS THAT BECAME EFFECTIVE OCTOBER 2003 FOR ALL HEALTH CARE PROVIDERS.**

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**Federal Anti-Kickback Statue**

**We at Park Physical Therapy strive to be compliant to all matters of federal, state, and contractual compliance. It is against federal and contractual obligations for a provider to "write-off" or discount deductible, co-insurance, or copayments, as these types of discounts violate the federal anti-kickback statue or provider collections provisions. Under such provisions, copayments are payable at the time of service and co-insurance and deductibles are payable upon confirmation from patient's carrier.**

**Federal and contractual obligations also require that we do not overcharge our patients more than their contractual obligations as instructed by their insurance policy. If ever you feel any fees you are asked to pay is not reflective of your insurance explanation of benefits or Medicare Remittance Advice, please contact Suzanne at (516)798-3789 ext. 122 promptly so we may address immediately.**

**If you have any questions, comments, or concerns regarding these provisions, please let us know so we may discuss your concerns privately to help us achieve our goal of providing the highest level of service while remaining compliant.**

**By signing this, I attest that I have read and understand the above Federal Anti-Kickback Statue.**

_____ _____

**Patient Signature** **Date**