SCORE Performance Medicine Intake Form

No Fault

Date:_____

Name: _____ DOB: _____ Circle: Male/Female

Address: _____ City _____ State _____ Zip _____

Cell Phone: _____ SSN: _____ Date of Injury: _____

Emergency Contact Information: _____

Primary Care Doctor: _____ Referring Physician: _____

Primary Health Insurance Company _____

ID # _____ Group # _____

Is your insurance in your name: Yes / No

Subscriber Name _____ Subscriber SSN _____

Subscriber Address _____ City _____ State _____ Zip _____

Subscriber Phone Number _____ Subscriber Gender: Male / Female

Subscriber DOB _____ Subscriber Relation to Patient _____

Subscriber Employer _____

Subscriber Employer Address _____ City _____ State _____ Zip _____

Please present your insurance card(s) for photocopy

Please complete the attached form to establish authorization to treat

SCORE Performance Medicine

NO FAULT INFORMATION

Patient Name: _____

Insurance Carrier: _____

Carrier Address: _____ City _____ State _____ Zip _____

Carrier Phone Number: _____

*Claim Handler's Name & Phone: _____

DATE OF INJURY/ACCIDENT: _____ STATE OF ACCIDENT: _____

BODY PART(S) REPORTED TO BE INJURED: _____

CLAIM NUMBER: _____ POLICY NUMBER: _____

Disability Status: Are you currently working?

____FULL DUTY ____LIGHT DUTY ____RESTRICTED DUTY ____NOT WORKING, date last worked_____

Brief Description of Accident and what treatment you have had since that date: _____

_____

_____

PATIENT TREATMENT WAIVER – NO FAULT

Thank you for choosing SCORE Performance Medicine for your Physical Therapy. We look forward to serving you and providing efficient, quality care. Since you have elected to treat with SCORE Performance Medicine for your injury you must be made aware of office policy. Should your No Fault Carrier deny your claim, you are responsible for 100% of billed charges.

I, (print name) _____ understand that the doctor does not participate with my private, backup insurance, or I do not have any. I understand and am aware of office policy regarding responsibility of medical bills. I have decided I wanted to continue with visits beginning today, and therefore assume responsibility for paying the bill.

_____

Signature Date

_____

Insurance Name

THIS FORM IS VALID FOR THE ENTIRE TREATMENT FOR THIS INJURY.

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____ , ("Assignor") hereby assign to _____ , ("Assignee")
(Print patient's name) (Print hospital or health care provider name)
all rights and privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____ , not withstanding any other agreement to the contrary.
(Print accident date)

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

_____ _____
(Print name of Patient) (Signature of Patient)

_____ _____
(Date of signature)

_____
(Address of Patient)

_____ _____
(Print name of Provider) (Signature of Provider)

_____ _____
(Date of signature)

_____
(Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)

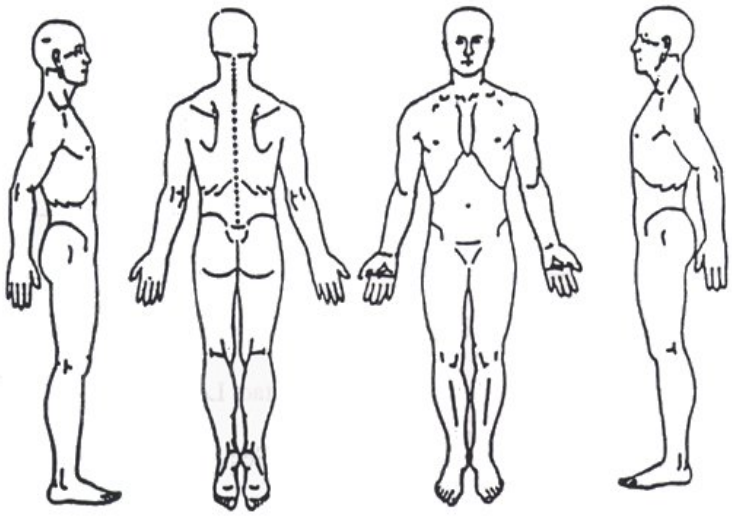
When and how were you injured?

What were the date of and results of any medical imaging and testing that you have had?

X Ray: _____ CT Scan:_____

MRI: _____ Other: _____

Please shade on this diagram where your pain and/or abnormal sensations are felt.



Please describe your pain in your own words (ie. dull, achy, sharp, throbbing, deep):

Please rate your pain over the last 2 weeks on this scale by circling the <u>lowest</u> (1), <u>current</u> (2), and <u>highest</u> (3) level of pain.

0 -1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 -10

Low range moderate pain range severe pain range

Medical History:

Please check any current medical conditions that you may have

Heart Attack/MI		**Vascular Disease**	
Cardiac Arrhythmia/Pacemaker		**Open Wounds**	
High Blood Pressure		**Osteoporosis**	
Coronary Artery Disease		**Osteoarthritis**	
Diabetes		**Rheumatoid Arthritis**	
Stroke CVA/TIA		**Lupus/SLE**	
Cancer		**Multiple Sclerosis**	
Epilepsy/Seizures		**Parkinson's Disease**	
Infectious Disease		**Migraines**	
Currently Pregnant		**Fracture**	
Vertigo		**Location of Fracture(s):**	

<u>Please list</u>

1) **Any other medical conditions that you have:**

2) **Past surgical history with the year surgery was performed:**

3) **Medications and supplements that you are taking:**

Have you experienced any of the following in the past month? (please check):

Recent bowl or bladder changes		**Cancer History**	
Abdominal Masses		**Night sweats, Fever**	
Unexplained tingling, numbness, weakness		**Blood in Sputum/Coughing up blood**	
Unexplained weight loss		**Pain that is not able to be relieved**	

Financial Policy
Appointment and Cancellation Policies

We are committed to providing you with the best possible care. We will gladly discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship.

Payment is due for services at the time services are rendered. This includes coinsurance, copayment, and deductible payments. If a check is returned for insufficient funds, you will be charged a bank fee in addition to the amount of the check.

After the insurance company has paid their portion of your claim, you are responsible for any unpaid charges on your bill. You will have 90 days to pay your bill before it is turned over to a collection agency. You will be responsible for any fees the collection agency charges.

I understand that my doctor has prescribed physical therapy, or I have chosen physical therapy without a doctor's referral. I understand that physical therapy is an ongoing process which requires regular attendance to be optimally effective. Consequently, I am aware that not attending scheduled sessions may be jeopardizing my progress.

I give my permission for SCORE Performance Medicine to provide information as needed to my insurance company.

Appointments: Please be on time for your appointments so that you may be given the full benefit of your scheduled treatment. Late arrival greater than 15 minutes may result in a shortened treatment or cancellation.

We require 24-hour notice of cancellation or a $25 fee may be assessed. You are directly responsible for this payment. Three episodes of absence from a physical therapy session without cancellation will result in discharge.

_____

Signature of patient or guardian (if minor) indicates acknowledgement and agreement of above

Patient Authorization for Use and Disclosure of Protected Health Information
Statement of Privacy Notice

We may disclose your health care information:

1. To other health care professionals within our practice for the purpose of treatment, payment, or health care operations
2. To your insurance provider for the purpose of payment or healthcare operations
3. To comply with State Worker's Compensation laws
4. To public health employees for preventing/controlling disease and reporting infectious exposures
5. In the course of any administrative of judicial proceeding or law enforcement purposes

Under the HIPPA federal privacy law you have the right to:

1. Request restrictions on certain uses and disclosures of your health information
2. Inspect and copy your health care information
3. Receive an accounting or disclosure of your protected health information
4. You have a right to a paper copy of this Notice of Privacy Practices at any time upon request

We reserve the right to amend this Notice of Privacy Practices at any time in the future. We are required by law to maintain the privacy of your health information.

If you have any questions regarding this notice of if you want more information about your privacy rights, please contact us at 716-302-3294.

My signature indicates my authorization and consent for SCORE Performance Medicine to use and disclose my protected health care information for the purposes of treatment, payment, and healthcare operations as described above.

_____

Patient's Name (print)

_____

Patient's Signature