Patient Express Registration

Excellent Choice Physical Therapy

Todays Date:

1. Patient Info

Please Fill-Out Entire Form Completely & Legibly.

Last Name _____ First Name _____ Age _____ ❑ Male ❑ Female

Street Address _____ City _____ State _____ ZIP _____

Home Phone (_____)_____ Cellular (_____)_____ ● Email Address (Required in order to watch "New Patient Video") _____

Occupation _____ Employer Name _____ Phone # (_____)_____

Emergency Contact Person _____ Phone # (_____)_____ If Patient is a MINOR: Parent/Guardian Name and Signature Here _____

Social Security #_____ Date of Birth_____/_____/_____ ❑ Single ❑ Married

Work Status: ❑ Currently Employed: ❑ Retired ❑ Disabled (__Total or __Temporary) ❑ Student (__P/T __F/T)

2. My Condition Info

ALL INFO REQUIRED

My injury/ailment is related to . . .

❑ AUTO/PERSONAL INJURY: Date of accident:_____/_____/_____

❑ WORK INJURY: Complete all information below.

Date of injury:_____/_____/_____

Your company HR person name_____

Insurance adjustor name_____

Insurance adjustor PH#_____

❑ NO INJURY: What do you think may have caused it?

I have already had . . .

❑ SURGERY: When and what type?

❑ PHYSICAL THERAPY BEFORE: When and where?

❑ HOME HEALTH Care: Are you still receiving it? __YES __NO

❑ OTHER care: What?

3. Payment Info

(check only one box)

I am paying TODAY by . . .

❑ **INSURANCE** and would like to . . .

__ Have you deal directly with them. I will assign my benefits to you by completing the **"Assignment of Benefits Form"** (Fees may apply in some cases). The following information is required prior to 1st visit.

My coinsurance/copay is $_____

My deductible is $ _____

__ Get a 30% discount by paying the entire bill at the time of service. I'll get reimbursement on my own. (Ask the front desk person for details)

❑ **WORKERS COMP** . . .

You must have all info provided under "My Condition...".

❑ **CASH, CHECK, CREDIT** and would like a . . .

__ 30% discount by paying at the time of service.

__ Payment plan and apply for "Financial Hardship"

❑ I have an **ATTORNEY** and would like to . . .

__ Get a 30% discount by paying up front. I'll get reimbursed after my case settles.

__ Wait until my case settles before paying. I will complete the "Attorney Lien" form. Fees may apply.

4. Referral Info

How did you hear about us?

❑ Friend or Family: ❑ Brochure: **Give details:**

❑ Internet: ❑ Insurance/Directory:

❑ Advertisement: ❑ Other:

❑ Physician/Dentist/Chiropractor/Nurse: Give details below.

Referring Physician/Person's Name _____

City _____ **State** _____

Phone # _____

EXCELLENT CHOICE
Physical Therapy, P.C.
"We treat you like family"

47-01 Queens Boulevard, Suite 402
Sunnyside, NY 11104
(718) 729-5947 Fax: (718) 729-9168

180 East Pulaski Road
Huntington Station, NY 11746
(631) 396-1595 Fax: (631) 396-1597

www.ExcellentChoicePT.com

To Our Patients:

It is the policy of *Excellent Choice Physical Therapy* (ECPT) and the responsibility of the patient to provide a credit card number to be retained by ECPT on file (just like at hotel check-in) to cover any balance owed after your insurance has been processed.

Should there be an outstanding balance that is deemed "patient responsibility" by your insurance company (or Medicare), we will charge your credit card account for the amount indicated as patient responsibility only.

You will receive from your insurance company an "explanation of benefits" (EOB) that will show the amount they deem as your (patient) responsibility.

If you have a deductible, co-insurance or a change to your co-pay that we are unaware of at the time of service, the explanation of benefits will indicate the balance due as "patient responsibility".

Please note that if you have secondary insurance coverage, we will submit any unpaid balance to the secondary insurance prior to any charges being made to your credit card. Once the secondary insurance is processed if there is any remaining balance we will call you first before charging on your credit card.

You will also receive a statement from us indicating the payment charged to your credit card.

Be assured, your credit card information will be retained in accordance with HIPAA regulations.

If you have no insurance, payment is due at the time of service.

Thank you for your cooperation.

Management of Excellent Choice Physical Therapy, PC
Effective : July 7, 2014

Important Company Policies for a Successful Relationship

We strive to provide you the best personalized care available. To make this possible we adhere to a set of very important guidelines. Please read them carefully, initial all the boxes, and indicate your agreement by signing on the other side of this form (bottom). *Please **INITIAL ALL BOXES** below*

☐ **Late Policy "10-minutes"**

Being late by more than 10 minutes will require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations are unpredictable. We do not allow appointment overlap because this undeservedly compromises the care of another patient.

☐ **24-Hour Advance Notice Fee**

If you wish to change or cancel an appointment we require a minimum 24-hour advance notice. Anything less will result in a $25 fee charged to your account. It costs us money to make appointments available to you. Whether you attend or not we still accrue the expenses (for staff wages, rent, etc.). We don't charge you the actual cost for that appointment but rather a mere $25 fee. We do NOT make money with this charge; it's only to act as a deterrent from making last minute changes. Advance notice allows someone else (who needs it) time to reserve it in place of you. Please be courteous and responsible. Thank you.

☐ **Copays are due upon arrival**

If you happen to forget your wallet or checkbook we may still be able to see you upon completion of an "Extension Request" form. This is a "promise-to-pay" form and carries a minimal fee that allows you to keep your appointment.

☐ **No-shows are bad**

If you fail to show for an appointment without notice all future appointments will be removed and a $25 fee assessed to your account. You may re-schedule appointments again on a "first come, first serve basis".

☐ **Cell phones must be shut OFF or silent.**

We realize emergencies may arise and therefore allow you to carry your cell phone during your session, however, please be courteous and set to silent mode or turn off. Thank you.

☐ **Children requiring supervision are NOT allowed to attend sessions with you.**

Unless your facility offers child care services, you may not bring children who require supervision with you to your appointment. If your child does not require supervision and is capable of waiting for you quietly then you may bring them. If any disturbance is caused to other patients or staff members you may be asked to terminate your session early and attend to your child.

☐ **Financial Hardship**

If you are experiencing financial difficulties and are unable to afford the cost of our services we have a "Financial Hardship Form" which may be filled-out. If you quality for financial assistance according to the Federal guidelines, we may legally assist you by waiving or discounting your (patient responsibility) portions of the bill. Ask the front desk person for assistance.

We look forward to building a successful relationship with you that lasts a lifetime

Assignment of My Benefits

IMPORTANT: All information must be **completed** or we will NOT be able to do the courtesy of dealing directly with your insurance.

1. Benefit Info

What is your deductible amount? $ _____ and Coinsurance %_____ (for the services you are seeking)

Are there any maximums? _____

If you don't know this information, call the "800" number on your insurance card. The front desk person may be able assist you.

2. Policy Info

Patient Name:_____ ID #_____ DOB_____

Insurance Policy 1 Name/Number/Group # (if applicable)_____

***IS PATIENT INSURED THROUGH SOMEONE ELSE'S POLICY?** Give their info here: (otherwise, skip this portion)

- Policyholder Name_____ Date of Birth_____ SSN_____
- Address (if different than Patient)_____
- Relationship to Patient: __ Spouse __ Parent __ Other: _____
- Employer _____ Ph#_____ Claim #_____
- Employer Address _____

Insurance Policy 2 Name/Number/Group # (if applicable)

_____

I hereby instruct and direct _____ insurance company to **pay by check made out to the "Healthcare Provider" to the right and mailed to** the address on the right (not mine). If my/this current policy prohibits direct payment to doctor/therapist, I hereby also instruct and direct you to make out the check to me and mail it to the address on the right (not mine) for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

Healthcare Provider info:

Excellent Choice Physical Therapy
180 East Pulaski Road Suite C,
Huntington Station, NY 11746
Long island : (631) 396-1595
4701 Queens Boulevard
Suite 402
Sunnyside, NY 11104
Queens: (718) 729-5947

This is a direct assignment of my rights and benefits under this policy.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

(Check each box and sign at the bottom)

q A photocopy of this Assignment shall be considered as effective and valid as the original.

q I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.

q I authorize the use of this signature on all insurance submissions.

q I authorize the "Healthcare Provider" named above to deposit checks made in my name.

q I authorize the "Healthcare Provider" named above to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

q I understand that I am financially responsible for all charges whether or not paid by insurance.

Dated this _____ day of _____, 20_____.

_----------_ _----------

CREDIT CARD AUTHORIZATION FORM

I, _____, hereby authorize
(Please PRINT NAME)

Excellent Choice Physical Therapy, PC, to charge my credit card for the amount deemed by my insurance carrier as "patient responsibility" or in the event I do not have insurance, any outstanding balance owed and/or charges for services rendered this date.

AMEX/ DISCOVER / VISA / MASTERCARD

(Circle One)

Credit Card Number:_____ Exp ___/____ Security Code___ _ _

Name on Credit Card_____

Billing Address _____PO Box_____

City _____State _____ Zip _____

Telephone ( ) _____-_____ Alternate Phone ( )_____-_____

Email_____ ***Phone or email required.***

Cardholder's Signature **Date**

_____ _____

Your completion of this authorization form helps us to protect you, our valued patient, from credit card fraud. Excellent Choice Physical Therapy, PC will keep all information entered on this form strictly confidential.

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name _____ **Date** _____

1. Describe your symptoms _____

_____

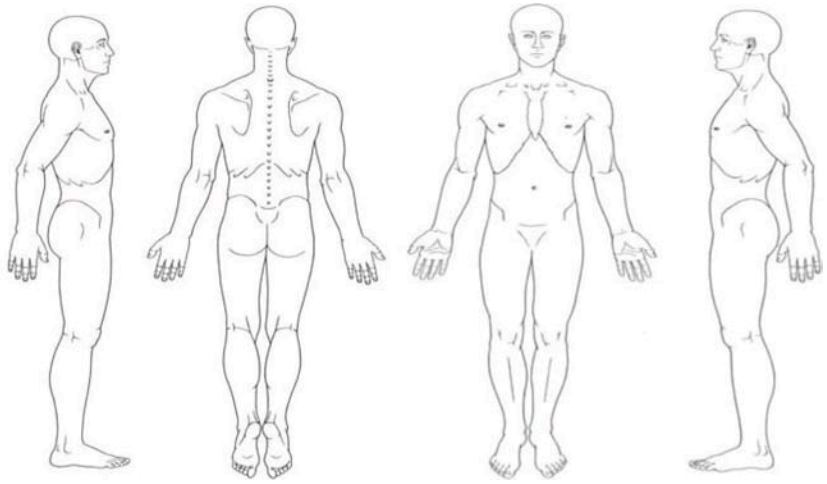
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

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8. Who have you seen for your symptoms?

① No One
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

10. What is your occupation?

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

_____

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

Patient Signature _____ **Date** _____

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PLEASE LIST ALL MEDICATIONS, VITAMINS OR SUPPLEMENTS YOU ARE CURRENTLY TAKING

NAME_____ DATE_____

Medication	Dosage	Frequency