PERFORM!
PHYSICAL THERAPY & PILATES

RELEASE OF INFORMATION:
The above Physical Therapy Center may disclose or request all or any part of the patient's records to any person or corporation which is or may be liable under a contract to the facility or the patient or to a family member of employer of the patient for all or part of the facility's charge, including, but not limited to, physical therapy services, insurance companies, Workman's Compensation/No fault carriers, welfare funds, or the patient's employers or any New York State or Federal agency per current rules and regulations. The Physical Therapy Center has the authority to reject any unreasonable request by an office or institution if such request might violate the patient's right to privacy.

RELEASE OF SIGNATURE:

I, _____hereby authorize Perform! Physical Therapy & Pilates PLLC. via

E-signature, to bill _____, my insurance Company, on my behalf, and to furnish any medical information requested concerning my condition or treatment.

ASSIGNMENT OF BENEFITS:
I hereby assign, and set forth to the above Physical Therapy Center, sufficient monies and /or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my medical care to cover the costs of the care and treatment rendered to me or my dependent. I understand I am financially responsible to the above Physical Therapy Center for charges not covered by this authorization.

DIRECT ACCESS:
I understand that the therapist practicing under direct access are required to give notice of advice that insurance may not cover services when rendered without a physician referral.

PRIVACY PRACTICES ACKNOWLEDGEMENT:
I have received the Notice of Privacy and I have been provided an opportunity to review it.

APPOINTMENT CANCELLATION/NO SHOW POLICY:

Perform Physical Therapy and Pilates is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen. Please call us at (516)-992-2282 a minimum of 24 hours prior to your scheduled appointment to notify us of any changes or cancellations. If prior notification is not given, you may be charged **$25.00** for the missed appointment. Thank you!

_____
Print Name

_____ _____
Signature of Patient or Responsible Party Date

NEW YORK VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM
(FOR ACCIDENTS OCCURING ON AND AFTER 3/1/02)

I, _____, ("Assignor") hereby assign to **Perform! Physical Therapy & Pilates PLLC,**
(Print Patient's Name)
("Assignee") all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 15 (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 _____, notwithstanding any other agreement to the country.
(Print Accident Date)

The 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 ISNURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONSCERNING 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 THEFT, DISTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR ANY 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)

_____ _____
(Address) (Date)

_____
(City, State) (Zip Code)

☐ Dr. Melinda Stoski PT, DPT, MS, OCS, CPI

_____ _____
(Signature of Provider) (Date)

☐ Dr. Siobhan Clarke PT

_____ _____
(Signature of Provider) (Date)

Perform! Physical Therapy & Pilates PLLC
2421 S Long Beach Road Suite 202,
Oceanside, NY 11572

PERFORM!
PHYSICAL THERAPY & PILATES

No Fault Insurance Information

Insurance Company Name:_____Phone #: _____

Address:_____City:_____State:_____Zip: _____

Date of Accident:_____Claim #:_____ Policy #: _____

Policy Holders:_____ Relationship: _____

Adjuster Name:_____Adjuster Phone #: _____

Private Insurance Name:_____Private Insurance ID #: _____

Attorney Information

Attorney Name:_____ Phone #: _____

Address:_____City:_____State:_____Zip: _____

No Fault

Patients should be prepared to pay their bills in full at the prevailing NYS fee schedule for No Fault and Workers Compensation. An exception can be made is we receive verification in writing from the No Fault Carrier to include the specific patient's name, medical benefit ceiling, deductible and whether or not it has not been met. The patient, or course, is responsible to pay the deductible, but with this information in writing we will bill the carrier directly for reimbursement. If for any reason, the carrier does not pay, the patient is directly responsible and agrees to pay the bills.

Minor Patients (Children under the age of 18)

The adult accompanying a minor to this office is responsible for the full payment. In order to authorize treatment, minor patients should not report to the office without a responsible adult present.

Patient Information:

Patient Name: _____ DOB: _____Marital Status: ☐ M ☐ S

Emergency Contact: _____ Relationship: _____

Phone: _____

If Patient is Minor, Name of Guarantor: _____

How Did You Hear About Our Office? _____

Primary Care Doctor: _____ City: _____State: _____

Phone #: _____

Chief Complaint: Injured or Painful body part(s): If bilateral, check both and circle the side which is worse.

Shoulder	Upper Arm	Elbow	Forearm	Wrist	Hand	Finger(s)	Hip	Thigh
☐ R ☐ L	☐ R ☐ L	☐ R ☐ L	☐ R ☐ L	☐ R ☐ L	☐ R ☐ L	☐ R ☐ L	☐ R ☐ L	☐ R ☐ L

Knee	Calf	Ankle	Foot	Toe(s)
☐ R ☐ L	☐ R ☐ L	☐ R ☐ L	☐ R ☐ L	☐ R ☐ L

Do You Have: ☐ Pain ☐ Weakness ☐ Numbness ☐ Stiffness

Other (Please Explain): _____

Pain Scale (0 – 10): 0 1 2 3 4 5 6 7 8 9 10 (Past Week) **WORST**:_____ **BEST**:_____ **CURRENT**:_____

Date Symptoms started: _____

Where did the injury occur?

☐ Work ☐ Home ☐ Auto ☐ Sports ☐ Other

Where you seen in the ER? ☐ Yes ☐ No

Any prior injuries or problem to same body part? ☐ Yes ☐ No Describe: _____

Describe in your own words how/when/where/ this injury occurred: _____

_____

_____

Medical History:

- ☐ Alzheimer's/Dementia
- ☐ Cardiovascular Disease/Hypertension
- ☐ Cauda Equina Syndrome
- ☐ Cerebral Vascular Accident
- ☐ Current Infection
- ☐ Diabetes Mellitus (Type): _____
- ☐ COPD/Emphysema
- ☐ Fibromyalgia
- ☐ Fracture or Suspected Fracture
- ☐ Depression/Anxiety
- ☐ Other (enter description below)

_____

- ☐ History of Cancer: (Type)_____
- ☐ Pacemaker
- ☐ Immunosuppression
- ☐ Lupus
- ☐ Muscular Dystrophy
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Parkinson's
- ☐ Rheumatoid Arthritis
- ☐ Traumatic Brain Injury

Surgical History: (Please List): _____

Allergies:_____

Current Medications: (Include Dosages)

☐ Prescription: _____

_____

☐ Over the Counter_____

☐ Herbals_____

☐ Vitamin/Mineral/Dietary Supplements: _____

☐ Not currently taking any medications