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

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
PERFORM! PHYSICAL THERAPY	MAXIMUM THERAPEUTIC BENEFITS REACHED	$120.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

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.

Head R L	Neck R L	Shoulder R L	Upper Arm R L	Elbow R L	Forearm R L	Wrist R L	Hand R L	Finger(s) R L
Upper Back R L	Lower back R L	Hip R L	Thigh R L	Knee R L	Calf R L	Ankle R L	Foot R L	Toe(s) R L

Do You Have: Pain A Wound Numbness A Mass Stiffness

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

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

_____

_____

Date injury occurred: _____

Date of Onset Symptoms: _____

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: _____

Medical History:

- ☐ Alzheimer's
- ☐ Cardiovascular Disease
- ☐ Cauda Equina Syndrome
- ☐ Cerebral Vascular Accident
- ☐ Current Infection
- ☐ Diabetes Mellitus Type 1
- ☐ Diabetes Mellitus Type 2
- ☐ Fibromyalgia
- ☐ Fracture Or Suspected Fracture
- ☐ High Blood Pressure
- ☐ Other (enter description below)

_____

- ☐ History Of Cancer
- ☐ Huntington's
- ☐ Immunosuppression
- ☐ Lupus
- ☐ Muscular Dystrophy
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Parkinson's
- ☐ Rheumatoid Arthritis
- ☐ Traumatic Brain Injury

Surgical History: (Location & Date): _____

Allergies:_____

Current Medications: (Include Dosages)

☐ Prescription: _____

_____

☐ Over the Counter_____

☐ Herbals_____

☐ Vitamin/Mineral/Dietary Supplements:_____

☐ Other_____

☐ Not currently taking any medications