ORANGE LAKE PHYSICAL THERAPY, PLLC

211 South Plank Rd. #3, Newburgh, NY 12550 • (845) 566-4303 Fax: (845) 566-4255

PATIENT INFORMATION/WORKERS COMPENSATION

First Name_____ Last Name_____
Address_____ City_____ State_____ Zip_____
Home Phone #_____ Work Phone #_____ Driver's License #_____
Date of Birth_____ SS#_____
M_____ F_____ Marital Status: M_____ S_____ D_____ W_____
Injured Area_____ Is injury work related? Y_____ N_____

How did you hear about us? _____

Name of Employer_____ Currently Working? Y_____ N_____
Address_____ City_____ State_____ Zip_____
Phone #_____ Occupation_____

NAME OF REFERRING PHYSICIAN_____
DATE OF RETURN VISIT TO REFERRING DOCTOR_____
PRIMARY DOCTOR_____

Please state the nature of your injury and how it occurred _____
_____ Date of Injury _____
Employer Name (at time of accident) _____
Employer phone # _____ Supervisor/Contact Person _____
Employers Policy # with Ins. Co. _____Adjuster/Case Mgr. _____
Compensation Ins. Carrier _____
Address _____ City/State/Zip _____
Phone # _____ W/C Claim # _____

If you have an attorney for this accident/injury, please furnish the information requested below:
Attorney's Name _____ Phone # _____
Address _____ City/State/Zip _____

Have you treated with a Chiropractor for this injury? _____ Attorney_____

IN THE EVENT THAT YOUR WORKERS COMPENSATION CLAIM IS DENIED, PLEASE PROVIDE THE FOLLOWING INFORMATION:

Name of private insurance carrier_____
Address _____ City _____ State _____ Zip _____
Phone # _____ Insurance ID# _____

I hereby give permission to Orange Lake Physical Therapy to bill my private insurance carrier in the event that my Workers Compensation claim is denied. In order to do so, I understand that I am responsible to provide the necessary authorizations and I am subject to the terms of my policy coverage. I further understand that if my private insurance denies payment or if I do not have private insurance, that I am responsible for all charges. I also understand that my claim must be verified/authorized before I may receive treatment.

Signature _____ Date _____

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Workers Compensation/No Fault

Are you currently receiving treatment from another medical professional with the exception of your medical doctor?

Yes_____ No_____

If yes, what type of treatment? _____

_____

Patient's signature

_____

Date

Name:_____ Date:_____

Do you now or have you had any of the following: (Please answer Yes or No)

	YES	NO
Breathing Problems	_____	_____
Cancer	_____	_____
Diabetes	_____	_____
High Blood Pressure	_____	_____
Blood Vessel Disease	_____	_____
Heart Attack	_____	_____
Pacemaker	_____	_____
Headaches	_____	_____
Joint Replacements	_____	_____
Metal Implants/Fragments	_____	_____
Arthritis	_____	_____
Nervous System Disorder	_____	_____
Known Allergies	_____	_____
Previous Surgery	_____	_____
Dizziness	_____	_____
Pregnant Now	_____	_____
Infectious Disease	_____	_____
Fractures	_____	_____

If you checked yes to any of the above, please explain and give dates:

_____

_____

List all current medications and state condition that they are used for:

_____

_____

_____

Emergency contact person:

Name:_____

Relaltionship:_____Phone#:_____

The above is correct to the best of my knowledge.

_____ _____

Patient's or Guardian's Signature Date

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APPOINTMENT POLICY AGREEMENT

I understand that my doctor has prescribed physical therapy for me and 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 and also may adversely affect my disability status (no-fault and workers compensation).

Please be on time for your appointments so that you may receive the full benefit of your scheduled treatment. Late arrival of 15 minutes or more may result in a shortened or cancelled treatment. We require 24 hours notice for cancellations. Multiple late arrivals, cancellations and/or "no-shows" will result in scheduling you on a call-in basis. Please schedule appointments at the end of the initial evaluation. We will schedule all of your appointments at once for your convenience. If you do not schedule all appointments at once, please do not assume that you automatically have the same appointments each week.

Signature:_____ Date:_____

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ASSIGNMENT OF BENEFITS/FINANCIAL POLICY

I hereby authorize the release of any medical information to my insurance company which may be necessary to process my insurance claim. I assign the payment of any medical benefits payable to Orange Lake Physical Therapy. I understand that I am financially responsible for all charges not paid for by insurance, including any and all co-payments, deductibles, collection costs or attorney fees. I understand that it is my responsibility to inform Orange Lake Physical Therapy of any changes in insurance coverage.

Co-payment amount:_____

If a check is returned for insufficient funds, you will be charged the bank fee in addition to the amount of your check which will then be due in cash. If you have any balance due on your account and it has not been paid within 90 days (unless other financial arrangements have been made), the account will be turned over to collections. Collection agency's charge 33% of the unpaid balance due. Should these additional costs be incurred, you will be responsible for the unpaid balance due plus the 33 %.

I understand and agree to comply with the Financial Policy explained above.

_____

Signature of Patient or Guardian (if minor)

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Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have reviewed the Notice of Privacy Practices:

Patient Name (Print):_____

_____ _____

Patient or Personal Representative Signature Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to patient:

_____

For Office Use Only

Documentation of Good Faith Efforts

Patient Name:_____ Date:_____

The patient presented for his/her procedure on this date and has reviewed a copy of the Orange Lake Physical Therapy, PLLC Notice of Privacy Practices. A good faith effort was made to obtain a written acknowledgement of review of the Notice. However, an acknowledgement was not obtained because:

_____Patient refused to sign

_____Patient was unable to sign because of medical reasons or emergency (will attempt to obtain acknowledgement at the next available opportunity).

_____Other reason _____

Signature of employee:_____ _____