

MEDICAL INSURANCE RECORD - ZELIK ZIEGELBAUM, RPT

Name _____ DOB _____ M _____ F _____
Last First

Address _____ City, State, ZipCode _____

Insurance Company _____ ID# _____ SS# _____

Primary Card Holder _____ DOB _____ SS# _____

Home Phone # _____ Work _____ Cell _____

Emergency Contact Name _____ Phone# _____

Who referred you to our office _____

List any difficulties with your health _____

List dates and any surgeries you have had in the past 5 years _____

Is this condition the results of a fall _____ If yes, describe (date, when, where and how)

I authorize payment of medical benefits to the undersigned physician or supplier for service rendered.

I authorized the release of any medical information necessary to process claims. I also request payment of government benefits either to myself or to the party who accepts this assignment.

Signed (Patient or Authorized Person) Authorize _____

Date _____

PRIVACY PRACTICES ACKNOWLEDGEMENT

Zelik Ziegelbaum R.P.T.
26 Manorhaven Blvd.
Port Washington, NY 11050
516 944-8798

I have received and have been presented with the opportunity to review the
Zelik Ziegelbaum Physical Therapy notice of Privacy Practices

✓ Patient/Spouse/Legal Guardian _____ Date _____
Patient declined Copy _____ Patient Declined to Sign _____ Employee Initials _____



CONSENT FOR TREATMENT

I acknowledge and understand that, in presenting myself for treatment at Zelik Ziegelbaum Physical Therapy, that I authorize and consent to the administration and performance of physical therapy treatments which may be provided by a physical therapist or other members of Zelik Ziegelbaum's staff. Minors must be accompanied by a Parent/legal guardian for medical care

✓ Patient/Spouse/Legal Guardian _____ Date _____
Witness _____ Date _____



AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION FOR PAYMENT

Non-Medicare Assignment & Release

I, the undersigned, certify that I have insurance coverage and assign directly to Zelik Ziegelbaum Physical Therapy all insurance benefits. A photocopy of the original is to be considered as valid as the original. I understand that I am financially responsible for all charges incurred for services rendered to me and I hereby agree to pay any and all charges that exceed or that are not covered by insurance. I hereby authorize Zelik Ziegelbaum Physical Therapy the release of information necessary to file a claim with my insurance company or Workmen's compensation carrier. I authorize the use of the signature on all insurance submissions. This order will remain in effect until revoked by me in writing.

✓ Patient/Spouse/Legal Guardian _____ Date _____

Medicare Assignment & Release

I, the undersigned, request the payment of authorized Medicare benefits be made on my behalf to Zelik Ziegelbaum Physical Therapy for any services provided to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorized releasing of the information to insurer or agency shown. In Medicare assigned cases, Zelik Ziegelbaum Physical Therapy agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered services. I authorize the use of this signature on all insurance submissions. This order will remain in effect until revoked by me in writing.

✓ Patient/Spouse/Legal Guardian _____ Date _____

PHONE AUTHORIZATION

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information PHI. The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means such as sending correspondence to the individual's office instead of the individual's home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CIRCLE ALL THAT APPLY)

Home Telephone # _____ OK to leave a message (Y or N)
Work Telephone # _____ OK to leave a message (Y or N)
Cell Telephone # _____ OK to leave a message (Y or N)

In completing and signing this form, I authorize that Zelik Ziegelbaum Physical Therapy may leave a message containing medical information for a period of 12 months from the date signed on this form.

If you would like to change any of the information on this form prior to the end of the time period stated above, you must contact Zelik Ziegelbaum Physical Therapy in writing and request the change. This form must be up to date, signed and on file in your chart prior to any medical information being left on an answering machine or with individuals you designate.

Patient/Spouse/Legal Guardian _____ Date _____ Witness _____ Date _____



ATTENDANCE POLICY

Late Arrivals – If a patient is more than 15 minutes late for an appointment it is the therapist's discretion as to whether or not the patient will be seen or needs to be rescheduled.

Cancellations – We request a minimum of 24 hours notice

No Shows – A \$25.00 fee will be assessed for each no-show. A patient will be discharged upon three no-shows for routine visits. The referring physician and/or caseworker (if applicable) will be notified.

Patient/Spouse/Legal Guardian _____ Date _____

Patients name _____

DX _____

Please be advised that the condition I am receiving Physical Therapy treatments for is not accident related and compensation is not being sought from any other company or individual.

X _____

Medication Management - Measurement 130 (G8427)

Name: _____

DATE: _____

[illegible]

PATIENT NAME:

DESCRIBE YOUR SYMPTOMS:

HOW DID YOUR SYMPTOMS START?

Patient Summary Form

PSF-750 (Rev:2/18/2009)

Instructions

Please complete this form within the specified timeline and fax to the specified fax number as indicated on Plan Summary or plan information previously provided.

*Fax number may vary by plan.

Patient Information

Patient name Last First MI			<input type="radio"/> Female <input type="radio"/> Male	Patient date of birth		
Patient address				City	State	Zip code
Patient Insurance ID#		Health plan		Group number		
Referring physician (if applicable)			Date referral issued (if applicable)		Referral number (if applicable)	

Provider Information

1. Name of the billing provider or facility (as it will appear on the claim form) ZELIK ZIEGELBAUM, RPT				2. Federal tax ID(TIN) of entity in box #1			
3. Name and credentials of the individual performing the service(s) ZELIK ZIEGELBAUM, RPT				4. Alternate name (if any) of entity in box #1			
5. NPI of entity in box #1 1407922198				6. Phone number (516) 944-8798			
7. Address of the billing provider or facility indicated in box #1 26 MANORHAVEN BLVD				8. City PORT WASHINGTON		9. State NY	
						10. Zip code 11050	

Provider Completes This Section:

Date you want THIS submission to begin:

--	--	--

Patient Type

- ☐ 1 New to your office
☐ 2 Est'd, new injury
☐ 3 Est'd, new episode
☐ 4 Est'd, continuing care

Cause of Current Episode

- ☐ 1 Traumatic ☐ 4 Post-surgical
☐ 2 Unspecified ☐ 5 Work related
☐ 3 Repetitive ☐ 6 Motor vehicle

Date of Surgery

--	--	--

Type of Surgery

- ☐ 1 ACL Reconstruction
☐ 2 Rotator Cuff/Labral Repair
☐ 3 Tendon Repair
☐ 4 Spinal Fusion
☐ 5 Joint Replacement
☐ 6 Other

Diagnosis (ICD code)

Please ensure all digits are entered accurately

1°					
2°					
3°					
4°					

Nature of Condition

- ☐ 1 Initial onset (within last 3 months)
☐ 2 Recurrent (multiple episodes of < 3 months)
☐ 3 Chronic (continuous duration > 3 months)

DC ONLY

Anticipated CMT Level

- ☐ 98940 ☐ 98942
☐ 98941 ☐ 98943

Current Functional Measure Score

Neck Index

--

DASH

--

(other)

Back Index

--

LEFS

--

Patient Completes This Section:

Symptoms began on:

--	--	--

(Please fill in selections completely)

1. Briefly describe your symptoms:

2. How did your symptoms start?

3. Average pain intensity:

- Last 24 hours: no pain ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 worst pain
 Past week: no pain ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 worst pain

4. How often do you experience your symptoms?

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

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)

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

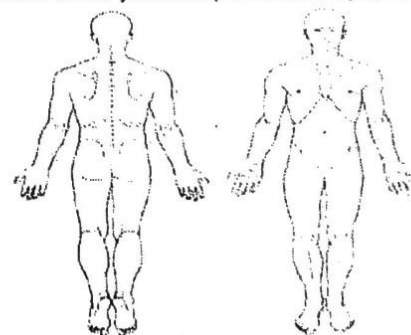
6. How is your condition changing, since care began at this facility?

- ☐ 0 N/A — This is the initial visit ☐ 1 Much worse ☐ 2 Worse ☐ 3 A little worse ☐ 4 No change ☐ 5 A little better ☐ 6 Better ☐ 7 Much better

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

- ☐ 1 Excellent ☐ 2 Very good ☐ 3 Good ☐ 4 Fair ☐ 5 Poor

Indicate where you have pain or other symptoms:



Patient Signature: X

Date:

ZELIK ZIEGELBAUM, R.P.T.

Registered Physical Therapist
26 Manorhaven Boulevard
Port Washington, New York 11050
(516) 944-8798
Fax: (516) 944-9354

DATE _____

I have been informed that you are not a participating provider with my insurance company. All reimbursement checks for my Physical Therapy treatments will be sent directly to me. It is my responsibility to forward payment to Zelik Ziegelbaum.

PATIENT SIGNATURE