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/LegalGuardian_____Date_____Witness_____Date____

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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____

Medicatic Management - Measur 130 (G8427)

Name: _____ DATE: _____

Prescription Medication	Dosage	Frequency	Reason For Use
Over the Counter Medication	Dosage	Frequency	Reason For Use
Herbal Medication	Dosage	Frequency	Reason For Use
Vitamins/Minerals Supplements	Dosage	Frequency	Reason For Use

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_____

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

○ Female ○ 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

ZELIK ZIEGELBAUM, RPT

1. Name of the billing provider or facility (as it will appear on the claim form)

2. Federal tax ID(TIN) of entity in box #1

ZELIK ZIEGELBAUM, RPT [1] MD/DO [2] DC [X] PT [4] OT [5] Both PT and OT [6] Home Care [7] ATC [8] MT [9] Other ____

3. Name and credentials of the individual performing the service(s)

4. Alternate name (if any) of entity in box #1

1407922198

5. NPI of entity in box #1

(516)944-8798

6. Phone number

26 MANORHAVEN BLVD

7. Address of the billing provider or facility indicated in box #1

PORT WASHINGTON

8. City

NY

9. State

11050

10. Zip code

Provider Completes This Section:

Date you want *THIS* submission to begin:

Cause of Current Episode

(1) Traumatic
(2) Unspecified
(3) Repetitive
(4) Post-surgical →
(5) Work related
(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° ____.____

Patient Type

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

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

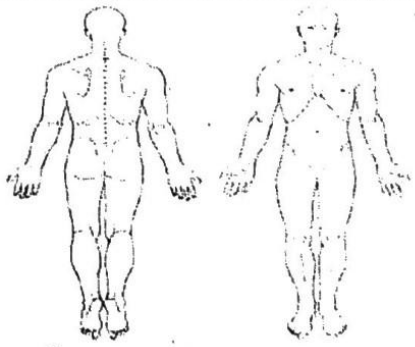
Neck Index | DASH | (other)
Back Index | LEFS

Patient Completes This Section:

(Please fill in selections completely)

Symptoms began on:

Indicate where you have pain or other symptoms:



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

Patient Signature: X _____ **Date:** _____