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

47602

PT/OT Patient Outcomes Form
(version 1.5)
www.palladianhealth.com/members

Palladian

Last Name | First name

PLEASE COMPLETELY FILL IN THE ONE CIRCLE THAT BEST DESCRIBES YOUR ANSWER. (Example: ●)

	Excellent	Very good	Good	Fair	Poor
1. In general, would you say your health is	○	○	○	○	○

The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	○	○	○
3. Climbing several flights of stairs	○	○	○

During the past week, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
4. Accomplished less than you would like	○	○	○	○	○
5. Were limited in the kind of work or other activities	○	○	○	○	○

During the past week, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
6. Accomplished less than you would like	○	○	○	○	○
7. Did work or other activities less carefully than usual	○	○	○	○	○

	Not at all	A little bit	Moderately	Quite a bit	Extremely
8. During the past week, how much did pain interfere with your normal work (including work outside the home and housework)?	○	○	○	○	○

These questions are about how you feel and how things have been with you during the past week. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past week...	All of the time	Most of the time	Some of the time	A little of the time	None of the time
9. Have you felt calm and peaceful?	○	○	○	○	○
10. Did you have a lot of energy?	○	○	○	○	○
11. Have you felt downhearted and depressed?	○	○	○	○	○

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
12. During the past week, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?	○	○	○	○	○

How would you rate the severity of your main problem on a scale from 0 (not severe) to 10 (worst imaginable)?

	Not severe	0	1	2	3	4	5	6	7	8	9	10	Worst imaginable
13. Right now		○	○	○	○	○	○	○	○	○	○	○	
14. On average		○	○	○	○	○	○	○	○	○	○	○	
15. At its best		○	○	○	○	○	○	○	○	○	○	○	
16. At its worst		○	○	○	○	○	○	○	○	○	○	○	

47602

17131

PT/OT Patient Intake Form
(version 1.5)
www.palladianhealth.com/members

Palladian

Last name | First name

PLEASE COMPLETELY FILL IN THE ONE CIRCLE THAT BEST DESCRIBES YOUR ANSWER. (Example: ●)

1. Why are you here today? If there are many reasons, please choose only the most important or most severe one.

O Neck	O Shoulder	O Hip	O Stroke rehabilitation	Other (also indicate region)
O Upper/ mid-back	O Elbow	O Knee	O Spinal cord rehabilitation	O Post-surgical
O Lower back	O Wrist	O Ankle	O Neurologic rehabilitation	O Fracture
	O Hand	O Foot	O Balance/coordination	O Other

2. When did this problem first begin?
O Less than 1 month ago O 1-3 months ago O 4-6 months ago O 7-12 months ago O More than 1 year ago

Has this problem...	No	Yes
3. ... resulted from a work injury (i.e. workers' compensation insurance claim)?	O	O
4. ... resulted from a motor vehicle accident (i.e. no fault insurance claim)?	O	O
5. ... recently been evaluated by a medical doctor?	O	O
Since this problem began, have you noticed...	**No**	**Yes**
6. ... so much weakness in both your arms that you are unable to lift them?	O	O
7. ... so much weakness in both your legs that you are unable to walk without help?	O	O
8. ... difficulty controlling your bowel or bladder, or have you been unable to urinate?	O	O
9. ... pain in your chest, shortness of breath, or coughing up blood?	O	O
10. ... that one leg felt more warm, more swollen, more red, or more tender than the other?	O	O
Have you recently...	**No**	**Yes**
11. ... had blurred vision, double vision, dizziness, or fainting?	O	O
12. ... had any type of infection, fever, or chills?	O	O
13. ... had any type of surgery, surgical procedure, or medical procedure?	O	O
14. ... lost a lot of weight without really trying to (i.e without being on a diet)?	O	O
15. ... had any type of accident, fall, or trauma?	O	O
Have you ever...	**No**	**Yes**
16. ... been diagnosed with cancer?	O	O
17. ... been diagnosed with osteoporosis (i.e. weak, soft, or brittle bones)?	O	O
18. ... been diagnosed with a weakened immune system?	O	O
19. ... used any injected drugs (i.e. non-prescription drugs)?	O	O
20. ... used steroids such as prednisone for more than 4 weeks?	O	O
Is this problem something that ...	**No**	**Yes**
21. ... you've had before?	O	O
22. ... generally gets worse (i.e more severe or frequent) with movement, activity, or exercise?	O	O
23. ... generally gets better (i.e. less severe or frequent) with rest?	O	O
24. ... was recently examined with diagnostic imaging tests such as x-rays, MRI scan, or CT scan?	O	O
25. ... is also being treated by a health professional other than a physical or occupational therapist?	O	O

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