EAST END OCCUPATIONAL THERAPY PLLC

Appointment Date:_____ Time:_____ Office:_____

Last Name:_____ First:_____ Sex: M F

Address:_____ City:_____ State:_____ Zip:_____

Home Phone #: _____ Work:_____ Cell:_____

DOB: _____ Soc Sec #:_____ Email Address:_____

Relationship to insured: Self Spouse Child Other **Patient Status**: Single Married Student Other

Who may we Thank for referring you to us?:

O Internet _____ **O** Doctor _____ **O** Family/Friend **O** Other _____

REFERRING PHYSICIAN:_____ **Phone #** _____

Are you receiving Home Health assistance? Y N If Yes, please specify:_____

Are you currently attending any other Therapy? Y N If Yes, please specify:_____

Have you attended Therapy earlier this year? Y N If Yes, please specify:_____

NF: IS THIS THE RESULT OF AN AUTO ACCIDENT? Y N

Date of Accident_____ NF application filed with Ins.? Y N

Name of policy holder if not patient:_____

WC: IS THIS THE RESULT OF AN INJURY AT WORK? Y N

Date Of Injury_____

Injury reported to employer? Y N

Are you currently working? Y N

Body Part/ Diagnosis

1. _____

2. _____

OFFICE USE ONLY

Procedures

1._____

Splint:_____

Injury Date: _____

How Injury Occurred:_____

Surgery Date:_____

Patient Employer:_____

Employer Address:_____ Phone: _____

Patient Attorney:_____

Attorney Address:_____ Phone:_____

PRIMARY INSURANCE INFORMATION:

Subscriber's Name:_____ Employer:_____

D.O.B._____ Soc. Sec. #_____

Insurance Carrier:_____ Claims address_____

Adjuster Name:_____ Phone #_____ Fax #_____

Member/Claim #_____ Group #_____

SECONDARY INSURANCE INFORMATION:

Subscriber's Name:_____ Employer:_____

D.O.B._____ Soc. Sec. #:_____

Insurance Carrier:_____ Claims address_____

Adjuster Name:_____ Phone #_____ Fax #_____

Policy/Claim #_____ Group #_____

SIGNATURE:_____ **DATE:**_____

EAST END OCCUPATIONAL THERAPY PLLC

Date: _____

Patient: _____
Employer: _____
Claim Group: _____
SS # / ID #: _____

I hereby instruct and direct _____ Insurance Company to pay a check made out and mailed to:

East End Occupational Therapy ***700-3 Union Parkway*** ***Ronkonkoma, NY 11779***
Company Address City, State, Zip

or

If my current policy prohibits direct payment to provider, I hereby also instruct and direct you to make out the check to me and mail it as follows:

East End Occupational Therapy ***700-3 Union Parkway*** ***Ronkonkoma, NY 11779***
Company Address City, State, Zip

For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize provider to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated this _____ day of _____, 20_____

_____ _____
Signature of Policyholder Witness

_____
Signature of Claimant, if other than Policyholder

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information. I authorize payment of medical benefits to the provider
East End Occupational Therapy

SIGNATURE: _____ DATE: _____

700 Union Parkway, Suite 3
Ronkonkoma, NY 11779
631-676-4185

Patient Name: _____ **Date:** _____

Patient Privacy Notification Form

How we may use and disclose Health Information about you

In Compliance with the Federal Government's Law (HIPAA) The Health Insurance Portability and Accountability Act of 1996. You the patient are hereby informed of the following Privacy rules in our office.

Treatment

We will use your health information for treatment purposes. Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, therapists notes will be available in your medical record to all healthcare professionals who may provide treatment or who may be consulted by staff members.

Payment

We may use and disclose your health information so that treatment that you received from us may be billed to and payment collected from you, an insurance company, or third party. Your health plan may request and receive information on dates of service, the services provided, and the medical condition being provided.

Health Care Operations

Your health information may be used as necessary to support the day-to-day activities and management of EAST END OCCUPATIONAL THERAPY. For example, information on the services you received may be used to support budgeting, financial reporting, and are necessary to operate our practices and make sure that all patients receive quality care.

Judicial and Administrative Proceedings

We may disclose protected information in response to a court or administrative order. We may also disclose information about you in certain cases in response to a subpoena or other lawful process or as required to do so by law.

Other uses and disclosures that require your authorization

Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Expiration Date of Authorization

This authorization is effective through _____/_____/_____unless revoked or terminated by the patient or the patient's personal representative.

Right to terminate or revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to
EAST END OCCUPATIONAL THERAPY.

Potential for Re-disclosure

Information that is disclosed under this Authorization may be re-disclosed.
The privacy of this information may not be protected under the federal privacy regulations.

To Avert a Serious Threat to Health or Safety

We may disclose protected health information about you, with some limitations, when necessary to prevent a serious threat to your health and safety, or the health and safety to the public or another person.

Persons Authorized to use or disclose information

Information will be used or disclosed by:

EAST END OCCUPATIONAL THERAPY and Staff

Name of Person/Organization

Persons to whom information may be disclosed

Information described above may be disclosed to:

_____

Name of Person/Organization

Rights of the Individual

- You may inspect or request a copy of information that is used or disclosed under this Authorization.
- The right to amend or submit corrections to your protected health information.
- The right to receive a printed copy of this notice.
- The right to inspect and copy your protected health information
- The right to an accounting of disclosed information.
- The right to restrict the use of protected health information and to receive confidential communications.
- You have the right to revoke authorization at any time.

Name of Patient (print or type):_____

Signature of Patient:_____

Date:_____

Signature of Patient Representative:_____

Relationship of Patient Representative to Patient:_____

MISSED APPOINTMENT POLICY

In order to ensure that you get treatment at your chosen time slot allowing you to maximize your care, we ask that patients attend their scheduled appointments punctually.

There are other patients who are asking for an appointment that *you* are currently occupying and we deny those patients of that time as a commitment to *you* so you can receive the care you need.

To cancel your appointment, you are required to ***call us 24 hours in advance*** of your scheduled appointment. We will issue you the courtesy of one warning as exception and if you do not provide us with the same courtesy, we reserve the right, at our discretion, to charge you a **$20.00** fee. If you do not show up at all there will be a **$50.00** No-Show fee (*dire emergency excluded*).

We at East End Occupational Therapy want to make it clear that we do not want to charge these fees but rather the courtesy of a phone call by you, to our office, ***24 hours in advance*** so we can offer that appointment time to someone else.

Please do not cancel your appointments for it will only delay your recovery.

I have read the above and understand that with exception of one warning, I agree to pay **$20.00** for cancelling or **$50.00** for a No-Show if I am delinquent with attending my scheduled appointments without the courtesy of ***24 hours advanced notice.***

Patient Signature: _____ **Date**: _____

COMMUNICATION CONSENT

EAST END OCCUPATIONAL THERAPY
700 UNION PARKWAY
SUITE 3
RONKONKOMA, NY 11779

It is the policy of East End Occupational Therapy PLLC not to release confidential information other than face to face without authorization to do so by alternative methods (Voice Mail/Answering Machines/Telephone). Any information that will be provided will be released only to the authorized person (s) listed below.

I authorize East End Occupational Therapy PLLC, and/or their staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes (please fill out all contact information).

Home Telephone: _____ - _____ - _____ YES ◯ NO ◯

Answering Machine: YES ◯ NO ◯

Work Telephone: _____ - _____ - _____ YES ◯ NO ◯

Cell / Voice Mail: _____ - _____ - _____ YES ◯ NO ◯

E-Mail: _____ YES ◯ NO ◯

Regular Mail: YES ◯ NO ◯

If you would like to have information released to someone other than yourself, please complete the following list of authorized people:

Spouse: _____ Tel: _____ - _____ - _____

Other (please indicate relation):_____ Tel: _____ - _____ - _____

Patient Signature: _____ **Date**: _____