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. ________________ OFFICE USE

2. ________________ 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	***868 Church St, Suite 4***	***Bohemia, NY 11716***
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	***868 Church St, Suite 4***	***Bohemia, NY 11716***
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:_______________________

EAST END OCCUPATIONAL THERAPY PLLC

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, therapist's 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:___________________

EAST END OCCUPATIONAL THERAPY PLLC

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**: ______________________

EAST END OCCUPATIONAL THERAPY PLLC

COMMUNICATION CONSENT

EAST END OCCUPATIONAL THERAPY
868 CHURCH STREET
SUITE 4
BOHEMIA, NY 11716

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**: ____________________________