PERFORMAX PHYSICAL THERAPY WELLNESS, PC
150 BAY SHORE RD. NORTH BABYLON, NY 11703

Date:_______________

Patient Name:____DOB:_____________

Address: ____
(Street) (City, State) (Zip Code)

Social Security Number: _______________________________

Home Phone:___________________ Cell Phone: ____________________ Email: _____________________

Referring Physician: ____________________________Primary Physician: ____________________________

Reason for your visit: ____

Have you had physical therapy for <u>this</u> condition before? No __ Yes __ When ___________________
Have you had **<u>any</u>** physical therapy this year? No ___ Yes ___ When ___________________________
Are you receiving **<u>any</u>** chiropractic services? No ____ Yes _____
Are you receiving **<u>any</u>** homecare services? No ____ Yes _____

WC INSURANCE CARRIER:____

DATE OF ACCIDENT: ___________________________

ADJUSTERS NAME: ________________________________ PHONE#: _________________________

EMPLOYER NAME:____

ADDRESS: ____ PHONE# ___________________

CITY AND STATE OF ACCIDENT: ____

CARRIER CASE# __________________________________ WCB# ______________________________

PRIVATE INSURANCE CARRIER: __________________________________ ID#: _________________

INSURED NAME; ____ DOB: _________________

IN CONSIDERATION OF SERVICES RENDERED OR TO BE RENDERED, I HEREBY ASSIGN TO THE PROVIDER, *PERFORMAX PHYSICAL THERAPY WELLNESS, PC* AND /OR ITS ASSIGNEES ALL RIGHTS, PRIVILEGES AND REMEDIES TO PAYMENT FOR SERVICES PROVIDED BY THE ASSIGNEE. I HEREBY INSTRUCT AND AUTHORIZE DIRECT ASSIGNMENT OF THE BENEFITS OF MY PHYSICAL THERAPY INSURANCE PAYMENTS, AND IN THE EVENT MY INSURANCE COMPANY ISSUES A CHECK TO ME DIRECTLY FOR SERVICES RENDERED BY *PERFORMAX PHYSICAL THERAPY WELLNESS PC*, I AGREE TO SIGN IT OVER TO *PERFORMAX PHYSICAL THERAPY WELLNESS PC* IMMEDIATELY.
IT IS MY RESPONSIBILITY TO KNOW AND UNDERSTAND MY PERSONAL INSURANCE PLAN(S) PHYSICAL THERAPY PARTICIPATING PROVIDER NETWORK, PLAN BENEFITS, AND LIMITATIONS. I AGREE TO NOTIFY *PERFORMAX PHYSICAL THERAPY WELLNESS, PC* IMMEDIATELY IF MY INSURANCE COVERAGE TERMINATES OR CHANGES DURING THE COURSE OF TREATMENT.

PATIENT'S SIGNATURE: ____DATE: __________________

150 Bay Shore Rd
North Babylon, NY 11703
P(631) 586-6616 F(631) 586-6617
Armand Diesso P.T. Jessica M. Torres, D.P.T

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was made aware a copy of the Notice of Privacy Practices is available to me. I did or had the opportunity to read it if I so chose and understand the notice.

Patient Name: ____
Please Print

Signature: ____Date: __________

Parent or authorized representative (if applicable)

I will allow release of my medical/billing information to:

____
Print Full Name

Relationship: _______________________

CLAIMANT'S AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

(Pursuant to HIPAA)

INSTRUCTIONS

To the Claimant: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) set standards for guaranteeing the privacy of individually identifiable health information and the confidentiality of patient medical records. By completing and signing this form, you authorize your health care provider to file medical reports with the parties that you choose (such as the Workers' Compensation Board, your employer's insurance carrier, your attorney or representative, etc.) by checking the appropriate boxes below.

You have the right to refuse to sign this Authorization. If you sign, you have the right to revoke this Authorization at any time by mailing a request to revoke to the health care provider. You have the right to receive a copy of this Authorization.

IMPORTANT: Failure to execute this authorization may interfere with your ability to obtain workers' compensation benefits.

CLAIMANT'S NAME	CLAIMANT'S SOCIAL SECURITY NUMBER	CLAIMANT'S DATE OF BIRTH
LIST ALL WCB CASE NUMBER(S) AND CORRESPONDING DATE(S) OF ACCIDENT FOR WHICH YOU ARE GRANTING AUTHORIZATION		

I, ____, hereby authorize my treating health provider,
Claimant's Name

Performax Physical Therapy Wellness, PC, to disclose the following described health information:
Health Provider's Name

____

____

This information can be disclosed to the following parties: *(check all that apply; give names and addresses, if known)* ☐

☒ New York State Workers' Compensation Board

☒ My current/former employer ____

☒ Workers' compensation insurance carrier(s) ____

☐ Third-party administrator ____

☐ My attorney/licensed representative ____

☐ The Uninsured Employer's Fund (this fund is responsible for paying the medical bills and lost wage benefits when an employer is uninsured.)

☐ Special Funds Conservation Committee (for cases under Section 25-a or 15-8 of the Workers' Compensation Law)

Section 25-a: If your claim is being reopened after being previously closed, the Special Fund for Reopened Cases may be responsible for paying your medical bills and lost wage benefits.

Section 15-8: If you had a medical condition that existed prior to this injury, the Special Fund for Second Injuries may be responsible for reimbursing your employer's insurance carrier after a period of time has elapsed.

Redisclosure: I understand that once the above-referenced health care provider discloses health information based on this Authorization, that health information is no longer protected by HIPAA and the Privacy Rule.
Expiration Date: This Authorization expires upon the final closing of the workers' compensation claim(s) for which it is executed.

I have had the opportunity to review and understand the content of this Authorization. By signing this Authorization, I confirm that it accurately reflects my wishes.

Printed Name of Claimant or Legal Representative	Signature of Claimant or Legal Representative	Date

If Authorization signed by a legal representative on behalf of claimant, state relationship to claimant__________________________ and basis for authorization (eg. Claimant is a minor; patient is deceased and representative is the claimant in a workers' compensation proceeding or represents the estate)____

TO THE HEALTH PROVIDER: Keep the original of this Authorization on file. A copy must be given to the patient/claimant upon request.
DO **NOT** SEND TO THE NEW YORK STATE WORKERS' COMPENSATION BOARD.

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PATIENT NAME:____

Patient Health Questionnaire

1. What brings you to Performax?____
2. When did your symptoms occur and how?____
3. Have you had physical therapy for this condition before?_________________________________
    1. If so, when?______________________________
4. If you are having pain, is the pain? (circle one) Constant (75-100%) Frequent (50-75%) Occasional (25-50%) or Intermittent (less than 25% of the time)
5. Can you rate your pain? If 0 is no pain at all and 10 is the worse pain you have ever felt where does your pain lie?(circle one) 0 1 2 3 4 5 6 7 8 9 10
6. Have you had any falls in the past 12 months? (circle one) YES NO When? ________________
7. Is there any past medical history we need to know about? (pacemaker, defibrillator, surgeries etc.)____
8. Do you have any allergies?____
9. Please list any medications you are currently taking

____

____

____

Emergency Contact: ____(______)_________-____________

Name Relationship

Who Can We Thank For Referring You To Our Office? ______________________________

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Dear Patient:

We will do our best to accommodate your schedule. In turn we ask that all appointments be scheduled in advance, even if it is same day. We also ask that you call us in the event that you are unable to keep your appointment.

There will be a $25.00 fee for all NO SHOW appointments.

If you have any questions regarding this policy, please do not hesitate to speak with the front office staff.

THANK YOU
PERFORMAX PHYSICAL THERAPY

Patient Signature: ______________________________ Date: _____________

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Armand Diesso, P.T. Jessica M. Torres, DPT

WEBSITE AND SOCIAL MEDIA RELEASE FORM

I, the undersigned, do hereby grant permission to Performax Physical Therapy Wellness, PC to post my and/or my child's story, photo, or other item, hereinafter referred to as “Materials” I submit to and for, the Performax Physical Therapy Wellness PC Web site, Twitter account, Facebook, Instagram and any promotional material.

I hereby release you, your representative, employees, managers, members, officers, parent companies, subsidiaries and directors from all claims and demands arising out of or in connection with any use of said “Materials”, including, without limitation, all claims for invasion of privacy, infringement of my right of publicity, defamation and any other personal and/or property rights.

I acknowledge and agree that no sums whatsoever will be due to me as a result of the use and/or exploitation of the “Materials” or any rights therein.

Name: ________________________Signature: ________________________________ Date: _____________

(MINORS ONLY)

I acknowledge that my child is under 18 years old and lacks the legal capacity to enter into binding agreements. Accordingly, I have read this Release and consent to my child's inclusion in the “Materials” will not contest the rights granted in this Release, and shall assist and support you in any and all legal proceeding for affirmation of this Agreement, should you choose to have a court of law affirm this Agreement.

Child's Name: ___________________________________

Parent or Legal Guardian Signature: ______________________________________ Date: __________

Parent or Legal Guardian Print: ____

○ **DECLINE**

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To: ___________________________________

Workers' Compensation guidelines allow 6-8 weeks for an initial course of treatment.

You must follow up with your physical to determine if your treatment needs to continue outside of these guidelines. If your physician prescribes additional treatment you will be given a new prescription to continue physical therapy, and a variance request will be submitted by the physician to your insurance carrier for approval.

Your current prescription expires on: ___________________________________.

We strongly suggest that you schedule your follow up appointments with your doctor in advance, to avoid any disruption in your treatment. It can take <u>1-3 weeks</u> to submit the paperwork and receive a response from the insurance carrier.

We appreciate your cooperation. If you have any questions, please do not hesitate to speak with our front office staff. We are always available to help you.

Patient's Signature:__________________________________
Date:__________________