QUEENSBORO OCCUPATIONAL THERAPY

REGISTRATION FORM

-- -- -- -- -- -- -- -- -- -- -- -- -- -- -- -- ***PATIENT INFORMATION*** -- -- -- -- -- -- -- -- -- -- -- -- -- -- -- --

TODAY'S DATE: _____ Cell Phone: _____

Patient's Name: _____ Home Phone: _____

Street Address: _____ Apt./Floor _____

City: _____ State: _____ Zip Code: _____

Sex: ☐ Male ☐Female Birth Date: _____ Age: _____ ☐Single ☐Marr ☐Div ☐Sep ☐Wid

Social Security Number: _____ Email: _____

Occupation: _____ Employed By: _____

Address: _____ Business Phone: _____

Chose QOT because referred to clinic by (please check one) Insurance Plan ☐ Hospital ☐ Yellow pages☐
☐Family_____ ☐☐ Friend _____ ☐Close to home/work☐

Name of Referring Doctor: _____ Phone: _____

Have you been treated by a Physical/Occupational Therapist (FOR ANY REASON) this year, *prior* to today? ☐NO ☐YES If "yes" How many times prior to today did you see the other Therapist? _____

Describe problem:

_____

How & When did problem first occur:

_____

Did you have surgery for this problem? ☐NO ☐YES If "yes" When?

_____

List Medical problems:

_____

List Medications and/or Allergies:

_____

_____

_____

-- -- -- -- -- -- -- -- -- -- -- -- -- -- ***INSURANCE INFORMATION*** -- -- -- -- -- -- -- -- -- -- -- -- -- --

Do you have Medical Insurance? ☐ No ☐ Yes

PRIMARY INSURANCE: _____ ID#:

_____

Subscriber's Name: _____ Related to Patient: ☐Yes ☐No

_____

If you have Medicare as your primary insurance, Are you/will you be receiving Home Health care? ☐YES ☐NO

SECONDARY INSURANCE: _____ ID#:

_____

Subscriber's Name: _____ Related to Patient: ☐Yes

☐No_____

Is condition related to EMPLOYMENT? ☐Yes ☐No Date of Accident:

_____

Is condition related to AUTO ACCIDENT? ☐Yes ☐No Date of Accident:

_____

Other Accident: ☐ ☐Yes ☐☐No Date of Accident:

_____

Please describe:

_____

_____

_____

*********IMPORTANT*********

PLEASE BE ADVISED IF ANY INCORRECT INSURANCE INFORMATION IS GIVEN TO US YOU WILL BE HELD RESPONSIBLE

I, ________________________________understand that if my insurance and/or supplemental insurance company does not remit payment/s to Queensboro Occupational Therapy, that I will be held responsible for the outstanding balance.

Signature ____ Date: __________________________

-- --

Attorney's Name: ____ Phone: _______________________________________

Address: _____________________________________ City: ______________________ State: _____ Zip Code: __________

-- --

In case of an emergency, who should be notified? ____

Telephone#: _____________________________________ Relationship to patient: __________________________________

PLEASE PRESENT YOUR

PRESCRIPTION AND/OR REFERRAL,

INSURANCE CARDS,

& PHOTO ID

TO THE FRONT DESK

REVISED 3/2012

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR
PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

PATIENT: _____

EMPLOYER: _____

CLAIM / GROUP: _____

SOCIAL SECURITY NUMBER / ID #: _____

I hereby instruct and direct that _____ (insurance company) to pay by check made out and mailed to:

Queensboro Occupational Therapy
Carlos Martins M.S. OTR/L CHT
107 Northern Blvd, Suite 308
Great Neck, NY 11021

OR

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

Queensboro Occupational Therapy

107 Northern Blvd, Suite 308
Great Neck, NY 11021

I request that payment of authorized Medicare/other insurance company benefits be made either to me or on my behalf to Queensboro Occupational Therapy, Carlos A. Martins, for any services furnished to me be the party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and CMS or its intermediaries or carriers any information needed for this or related Medicare claim/other insurance company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information).

I also authorize Carlos A Martins, my occupational therapist, to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated: _____

Signature: _____

Witness: _____

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

1, _____, understand that as part of my health care, *Queensboro Occupational Therapy P.C.* originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plan for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that *Queensboro Occupational Therapy P.C.* is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that *Queensboro Occupational Therapy PC* reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should *Queensboro Occupational Therapy P.C.* change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

_____
Patient's signature

_____
Date

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of *Queensboro Occupational Therapy's* **Notice of Privacy Policies,** detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice.

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed: _____ Date: _____

If not signed by patient, please indicate relationship to patient (e.g. spouse)

Relationship: _____ Witness by: _____