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:** _____

WORKERS COMPENSATION INSURANCE INFORMATION SHEET

PATIENT NAME: _____

DATE OF ACCIDENT: _____

PLACE OF ACCIDENT: _____

BRIEFLY EXPLAIN HOW ACCIDENT OCCURRED:

_____

_____

EMPLOYER'S NAME AND ADDRESS:

_____

_____

_____

TELEPHONE NUMBER: _____

SUPERVISOR'S NAME: _____

WORKERS' COMPENSATION INSURANCE COMPANY NAME AND ADDRESS:

_____

_____

_____

TELEPHONE NUMBER: _____

CASE NUMBER: _____

ARE YOU WORKING NOW? YES _____ NO _____

***** PLEASE NOTIFY THIS OFFICE IF YOU RECEIVE ANY INFORMATION REGARDING YOUR CASE OR MEDICAL COVERAGE**

***** YOU MUST NOTIFY OFFICE IF YOU ARE GOING TO SEE ANY INSURANCE DOCTORS**

***** IF YOU HAVE ANY ADDITIONAL TESTING (MRI'S, XRAYS) PLEASE BRING THE RESULTS OF TESTING TO THIS OFFICE**

I AM AWARE THAT QUEENSBORO OCCUPATIONAL THERAPY, CARLOS MARTINS MUST BE NOTIFIED OF ALL INSURANCE MEDICAL EXAMS (IME). IF I FAIL TO REPORT DENIAL OF TREATMENT I AM RESPONSIBLE FOR ALL FEES FROM THE EXAM DATE.

SIGNATURE: _____

DATE: _____

NOTICE THAT YOU MAY BE RESPONSIBLE FOR MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE, OR IF COMPENSATION CLAIM IS DISALLOWED, OR IF AGREEMENT PURSUANT TO WCL §32 IS APPROVED

WCB CASE NO. (If Known)	CARRIER CASE NO. (If Known)	DATE OF INJURY	NATURE OF INJURY OR ILLNESS	INJURED PERSON'S SOC. SEC. NO.

CLAIMANT	NAME	ADDRESS	APT. NO.
EMPLOYER			
INSURANCE CARRIER			

You may become responsible for the medical costs of treatment for your illness or condition with the provider listed below if (1) you fail to prosecute the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.

I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment.

Claimant's Signature_____ Date _____

Provider's Name and Address _____

TO THE CLAIMANT

Workers' Compensation Board Regulation 325-1.23 permits your doctor or therapist to request that you sign this A-9 notice. By signing this notice, you acknowledge your obligation to pay the provider's fees for the services you receive if it turns out that such fees are not legally required to be paid by your employer or its workers' compensation insurance carrier and if such fees are not covered by other insurance. The employer or carrier may not be required to pay the doctor's fees if, for example, you fail to file a claim for workers' compensation, or fail to notify your employer of your injury or illness, or fail to attend a Board hearing if your employer challenges your right to benefits. Even if you make all required efforts to prosecute your claim, the Workers' Compensation Board may still find that you are not entitled to benefits. In such cases, this notice advises your health provider that you acknowledge your personal liability for payment of his/her bills.

Workers' Compensation Law Section 32

The A-9 notice also covers instances in which a claimant with an existing valid workers' compensation case comes to an agreement with his/her employer or its insurance carrier settling his/her case in accordance with Section 32 of the Workers' Compensation Law. A Section 32 agreement may include a provision which relieves the employer or carrier of the liability to pay future medical bills associated with the case. Your health care provider may ask you to sign this A-9 notice to insure that you acknowledge your personal liability for payment of his/her bills if you have waived your right to future medical benefits under a Section 32 agreement.

If you have any questions, contact your attorney or licensed hearing representative, if you have one. You may also contact your local district office of the Workers' Compensation Board.

TO THE HEALTH CARE PROVIDER

This notice is meant to advise the workers' compensation claimant that he/she may be responsible for payment. Failure of the claimant to sign this form does not relieve the provider of the obligation to treat the claimant, nor does it negate the claimant's responsibility for payment.

Keep the original of this form for your records and give a copy to the claimant. **Do not file with the Workers' Compensation Board.** You will receive Notices of Decisions in which the compensability of a claim, authorization of treatment, or payment of medical bills is included. You will also be notified if the claimant submits a Section 32 Agreement with the Board for approval. Do not bill the claimant unless and until you receive a Board decision finding that 1) claimant failed to prosecute the claim, or 2) the claim is denied, or 3) the treatment is not causally related to the work injury, or 4) a Section 32 agreement relieving the carrier of liability for medical treatment is approved.