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AUTO OR NON-WORK RELATED ACCIDENT

Patient & Payor Information Form

All Patients or Patients' Legal Representative, please complete all Sections

(1) Patient Name (Full Legal Name or as on Insurance Card)

_____
Last First Middle Initial

_____
Street Address Apt# City State Zip Code

☐ Home ☐ Mobile ☐ Work Phone Number

☐ Home ☐ Mobile ☐ Work Phone Number (Alternative)

Emergency Contact Name and Phone Number*

Email Address*

Date of Birth (MM/DD/YYYY) _____/_____/_____ Legal Sex**: _____ Preferred Name *: _____

How would you like to receive appointment reminders? Call ☐ Text ☐ E-mail ☐

(2) Why did you choose SPEAR? (Select one answer only)

- ○ Doctor
- ○ My insurance
- ○ Friend or family
- ○ Walked by/ in
- ○ Mount Sinai Network
- ○ Hospital for Special Surgery Rehab Network
- ○ I'm a Returning Patient
- ○ Yelp!
- ○ Google Maps/Reviews
- ○ Zocdoc
- ○ Other (please describe): _____
- ○ Social media (Facebook, Instagram or Twitter)
- ○ General online search
- ○ betterPT

(3) Auto or Non-Work Accident Claim

The Claim will be paid by:_____ Your Personal Car Insurance_____ Liability Claim (Another Person's Insurance)

Insurance Company:_____Claim #: _____

Adjustor's Name:_____ Phone #(_____)_____-_____ Fax #(_____)_____-_____

Claim Mailing Address:_____
Street Address Apt# City State Zip Code

If pursuing litigation:
Name of Law Firm :_____Name of Attorney: _____

Address of Law Firm: _____
Street Address Apt# City State Zip Code

Sign: A or B

A) I understand that I and my attorney must agree to the terms of SPEAR Physical Therapy, LLC "Letter of Protection/Lien" in order for a liability claim to be considered as a payment source:

Patient's Signature_____

B) I understand that if I am using my personal car insurance I must assign payment benefits to SPEAR Physical Therapy, LLC and be prepared to pay should I exhaust the medical funds:

Patient's Signature: _____

*May be used for your appointment reminders, home exercise programs, response inquires, and/or other SPEAR updates.

**Please be aware that your name and sex listed on your insurance must be used on documents pertaining to insurance billing and correspondence.

All Patients or Patients' Legal Representative Please Sign Section 7 on Page 2

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AUTO OR NON-WORK RELATED ACCIDENT
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(4) Medical Insurance Information (please provide a copy of Insurance card or complete this section in the event that your Auto or Non-Work Accident claim is denied)

Ins. Co. Name:_____ **Ins. Co. Phone #:** _____

Insured's Name:_____ **Insured is**____**Patient**____**Spouse**_____**Parent**

Legal Gender: _____ **Date of Birth (MM/DD/YYYY)** _____/_____/_____

Patient ID #:_____**Group. #**_____ **Policy/Plan #:** _____

Claims Mailing Address: _____
Street City State Zip Code

Employer Name:_____**Employer Phone # (**____**)**_____**-** _____

Address: _____
Street City State Zip Code

(5) Credit Card Payment Authorization Would you like an e-mail receipt with each transaction? Yes ☐ No ☐

I hereby authorize S.P.E.A.R. Physical Therapy , PLLCto charge my credit card for services rendered and/or products supplied until this authorization is revoked by me. It is my responsibility to notify S.P.E.A.R. Physical Therapy, PLLCany changes regarding this credit card authorization.

Name on Card		Signature/Date
Credit Card Type ☐ MasterCard ☐ Visa ☐ American Express ☐ Discover		Credit Card Number
Expiration Date	Security Code	Billing Zip Code

(6) Payment Authorization: ***(Initials required for all 3 statements)***

_____ **Guarantee of Payment**

Initials **I understand that all payments designated as 'the patient's responsibility' such as co-insurances and deductibles are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed "my responsibility" by the billing statement due date.**

_____ **Health Insurance Option** (Copy of Insurance Card Required)

Initials **I agree to SPEAR Physical Therapy, LLC to file my Health Insurance within the required claims filing period should my Personal Auto or the other party's insurance deny the claim, exhaust the benefits or fail in any way to pay per the agreed upon terms.**

_____ **Certification of Information**

Initials **I certify that the information I have provided SPEAR Physical Therapy, LLC for payment including, but not limited to, related accidents, illnesses or other insurers is accurate and truthful.**

(7) Signature/ Date:

I attest, to the best of my knowledge, the above information is accurate and true.

_____ _____

Patient or Legal Representative's Signature **Today's Date**

All Patients or Patients' Legal Representative Please Sign Section 7 on Page 2

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I,_____, ("Assignor") hereby assign to_____, ("Assignee")
(Print patient's name) (Print hospital or health care provider name)
all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on_____, not withstanding any other agreement
(Print accident date)
to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

(Print name of Patient)	**(Signature of Patient)**
	(Date of signature)
(Address of Patient)	
(Print name of Provider)	**(Signature of Provider)**
	(Date of signature)
(Address of Provider)	

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MEDICAL HISTORY / SUBJECTIVE INFORMATION

Name:_____ Date: ____/____/____ Birthdate: ____/____/____ Age:_____

Was a prescription given to the front desk? Y N

Referring Physician:_____ Phone #: _____

Address: _____

Condition to be treated:_____ Date Condition Began: _____

(Please check all that apply)

____ Heart Disease ____ Diabetes ____ High Blood Pressure ____Pacemaker

____ Cancer ____ Tuberculosis ____ Visual Impaired ____ Epilepsy

____ HIV /AIDS ____ Arthritis ____ Hearing Impaired ____ Fibromyalgia

____ Stroke ____ Asthma ____ Latex Allergy ____ Scoliosis

____ Osteoporosis ____ Hepatitis ____ Other (if checked please explain _____)

Therapist's comments: _____

_____

Have you had surgery for your condition? Y N If yes, date:_____

Is condition related to Auto Accident? Y N If yes, date: _____

Is condition related to non-work accident? Y N If yes, date: _____

Is condition related to work accident? Y N If yes, date: _____

Have you had any injections for your condition? Y N If yes, date:_____

Please list any diagnostic tests you have had for this condition: _____

Please list any medications that you are taking: _____

What are your current symptoms?_____

How the injury or problem occurred?_____

Please rate your pain using a 0 – 10 scale (0 = no pain, 10 = the worst pain you can imagine)

Worst pain since onset:_____ Best pain since onset:_____ Today's pain:_____

Where is your pain or problem located?_____

Is your pain? Constant Intermittent Dull Sharp Other _____

What makes your pain / problem better?_____ Worse?_____

Is there pain present at night? Y N What position helps you to sleep? _____

Have you had PT for this condition? Y N If Yes Where?_____

Have you had chiropractic services for this condition? Y N If Yes Where?_____

Therapist's Comments:_____

_____

Employment History:

Are you currently working? Y N If no, how many total days of work have you missed?_____

Are your work duties? Full Restricted How many hours per week do you work?_____

Who is your employer?_____

What type of work do you do?_____

What activities in your daily life or work duties have been most affected by your problem?_____

_____

What do you hope to accomplish with therapy?_____

_____

Are you exercising at home? Y N If yes, what type?_____

Are you using heat or cold? Y N If yes, what type?_____

Are you wearing a sling or brace? Y N If yes, what type?_____

Do you smoke? Y N If yes, how much?_____

What type of non-work activities are you involved in?_____

When are you scheduled to see your doctor again?_____ .

Therapist's comments:_____

_____

Therapist Signature:_____

To the best of my knowledge and belief, the information I have given is complete and true. I hereby give my consent to receive therapy services at SPEAR Physical Therapy, LLC

I have received a copy of The Patient/Client Rights and Responsibilities Information Sheet.

Patient Signature:_____Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been given the Notice of Privacy Practices for SPEAR Physical Therapy, LLC. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to SPEAR Physical Therapy, LLC to release any of my protected healthcare information.

_____

Patient's or Authorized Representative's Printed Name & Date

_____

Patient's or Authorized Representative's Signature

☐

CONSENTS AND DISCLOSURES

Consent for Care and Treatment: I, the undersigned, do hereby agree and give consent to receive rehabilitation therapy treatment and any supplementary services that are deemed medically necessary or appropriate by my therapist and or treating provide. However, I understand the practice of rehabilitation medicine is not an exact discipline and I acknowledge that no guarantees have been made to me regarding treatment.

Consent for Care and Treatment Minor: I, the undersigned, do hereby agree and give consent to receive rehabilitation therapy treatment and any supplementary services that are deemed medically necessary or appropriate by my therapist and or treating provide to my child _____. However, I understand the practice of rehabilitation medicine is not an exact discipline and I acknowledge that no guarantees have been made to me regarding treatment.

REFERRAL AUTHORIZATION: Your insurance carrier may require a referral from your primary care physician for our services. Please be aware that it is your responsibility to obtain all necessary referrals prior to therapy. If your insurance carrier required an authorization for service, no service will be rendered until the authorization is obtained. Furthermore, we may be required to contact your doctor for a treatment order referral for services.

RELEASE OF INFORMATION: I authorize **S.P.E.A.R.** Physical Therapy to disclose all or part of my medical records to any person, corporation or agency when required for the collection of benefits or payments of charges

I, the undersigned, hereby consent to receive notifications from **S.P.E.A.R.** Physical Therapy, which notifications may include my PHI, by following methods of communications that I indicate below.

☐ Mobile Device: ( )_____ ☐Text Message: ( ) _____

☐Email: _____

I, the undersigned, hereby give my consent to Spear Physical Therapy office staff to discuss my medical condition or billing concerns with the person/s I have designation below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

CANCELLATION AND/OR NO-SHOW POLICY: S.P.E.A.R. Physical Therapy, PLLC urges you to keep every appointment, as consistent treatment will expedite your recovery.

Your Physical and or Occupational therapist will speak to you on our Back to Life Agreement. Arrival more than 15 minutes after the time of your scheduled appointment may be considered a failed appointment.

MEDICARE PATIENTS ONLY: Are you currently receiving Home Health Care Services? Y: N:

If yes, please indicate you have a discharge letter for services. Date of Discharge Letter: _____

MOTOR VEHICLE ACCIDENT INJURIES ONLY: If you are receiving care for injuries from a motor vehicle accident. In what state did the accident occur?

_____

Insufficient Funds: In the event a check is returned to us for insufficient funds a fee of $34 will be imposed along with the original payment.

ASSIGNMENT OF BENEFITS: I authorize payment of my Medicare and/or Insurance benefits to be made directly to S.P.E.A.R. Physical Therapy, PLLC on my behalf for physical therapy services rendered. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me, I will endorse such payments to S.P.E.A.R. Physical Therapy, PLLC within five (5) days of receipt of such payment.

Patient's Signature Date

Print Name

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE FEEL FREE TO SPEAK TO YOUR THERAPIST, HIS/HER DESIGNEE OR THE HIPAA PRIVACY OFFICER.

S.P.E.A.R. Physical Therapy, PLLC is committed to maintaining and protecting the confidentiality of your personal information. This Notice of Privacy Practices is being provided to you as a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). It will inform you about the ways in which we may use and disclose your health information, and the safeguards we have put into place to protect it. It also describes your rights and certain obligations we have regarding the use and disclosure of your health information.

OUR DUTIES TO YOU REGARDING YOUR PROTECTED HEALTH INFORMATION

"Protected Health Information" is individually identifiable health information expressed in the form of oral, written or electronic communications. This information includes demographic information such as your age, address, email address, and other information that relates to your past, present or future health condition and related healthcare services. S.P.E.A.R. Physical Therapy, PLLC is required by law to:

- Make sure your health information is kept private.
- Give you this notice of our legal duties and privacy practices related to the use and disclosure of your protected health information.
- Follow the terms of the notice currently in effect.
- Communicate any changes in this notice to you.

GOVERNMENTAL PRIVACY LAWS AND REGULATIONS

There are several other federal, state and city privacy laws that provide stronger restrictions about the use and disclosure of health information. The stricter laws have been taken into consideration in developing our policies and this notice of how we will use and disclose your protected health information.

HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION

The following categories describe different ways that we use and disclose your health information. We will not use your confidential information or disclose it to others without your authorization, except for the following purposes:

Treatment. We may use and/or disclose your confidential health information to provide you with treatment and/or services. This includes your therapist's recommendation(s), and those of other professionals/paraprofessionals including clerical, coordination and management staff.

Payment. Your protected health information will be used, as needed, to bill and collect payment for treatment and services provided to you. We may share information about a treatment and/or service you may receive to your health insurer to receive approval for payment.

Health Care Operations. We may use and disclose health information about you for regular health care operations. The medical staff in this practice will use your health information to assess the care you received and the outcome of your case compared to others like it. Your information may be reviewed for risk management or quality assessment/improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services we provide.

We will share your protected health information with third-party "business associates" who perform various activities for the practice. The business associates will also be required to protect your health information.

We may remove information that identifies you from this set of health information so others may use it to study health care and health care delivery without learning your identity.

Appointment Reminders. We may use and disclose health information to contact you as a reminder that you have an appointment for treatment or care in our Practice. These reminders will not identify the purpose of your visit.

Required by Law. We will disclose health information about you when required to do so by federal, state or local laws.

Public Health Activities. We may disclose your confidential health information for the following public health activities and purposes:

- To report health information to public health authorities that are authorized by law to receive such information for the purpose of preventing or controlling disease, injury or disability;
- To report child abuse or neglect to a government authority that is authorized by law to receive such reports;
- To report information about a product or activity that is regulated by the US Food and Drug Administration (FDA) to a person responsible for the quality, safety or effectiveness of the product or activity;
- To conduct post-marketing surveillance, as required; and
- To alert a person who may have been exposed to a communicable disease, if we are authorized by law to give this notice.

Legal Proceedings. We may release protected health information about you in response to a court or administrative order if you are involved in a lawsuit or dispute. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request.

Law Enforcement. We may release health information if asked to do so by law enforcement officials:

- In response to a court order, subpoena, warrant, summons or similar process.
- To identify or locate a suspect, fugitive, material witness or missing person.
- About the victim of a crime if, under certain circumstances, we are unable to obtain the person's agreement.
- About the death we believe may be the result of criminal conduct.
- About criminal conduct at the Practice.
- In emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Research. Under certain circumstances, we may use and disclose your confidential information for research purposes without an authorization. An authorization would not be necessary if your identifying information was removed.

Workers' Compensation. We may release your health information to comply with Workers' Compensation Laws and other similar legally established programs. The programs provide benefits for work-related illness or injury.

Promotional Gifts. We may use your confidential health information so that we may provide you with nominal gifts. We will not disclose your confidential information to other companies for their marketing purposes.

Health Related Benefits and Services. We may use and disclose health information to inform you about health-related benefits or services that may be of interest to you. You may be contacted by the Practice regarding general health-related products and services and/or health-related products and services targeted to your specific health status or condition, but only where we believe those products or services may benefit you. If the communication is targeted to you, it must explain why you were targeted and how the product or service relates to your health. Any communication you receive must identify the Practice as the source of the communication, inform you if we received any payment for making the communication,

and contain instructions about how you may request that we not contact you further about such health-related products and services.

Criminal Activity. Under certain Federal and state laws, we may disclose your protected health information if we believe that its use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose your health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Government Functions. We may disclose your health information to the U.S. Military or to authorized federal or state officials for purposes specified by federal law.

Coroners, Funeral Directors, and Organ Donation. We may disclose your health information to a coroner or medical examiner. This may be necessary to identify a deceased person or to determine the cause of death. We may also disclose protected health information to funeral directors as authorized by law to assist them in carrying out their duties. Protected health information may also be used and disclosed for organ eye and tissue donations if you have previously agreed to organ donation.

Parental Access. Various New York State laws determine what protected health information can be disclosed to parents, guardians, and persons acting in a similar legal status. We will act consistently with the law and will make disclosures only when necessary.

Individuals Involved in Your Care. Unless you object, we may use or disclose your health information to notify or assist in the notification of a family member or personal representative of your location, your general condition, or death. If you are present, you will have the opportunity to object to this type of use or disclosure. If you are unable to decide or if it is an emergency, we may disclose information that is directly relevant to the person's involvement in your healthcare, if we determine that it is in your best interest to do so.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Although your health record is the physical property of S.P.E.A.R. Physical Therapy, PLLC, the information belongs to you. You have the following rights regarding your protected health information. You may make any of the following requests by completing a "HIPAA Patient Rights Request Form" or by submitting a written request to our office.

Right to Inspect and Copy. You have the right to both inspect and obtain a copy of your protected health information that is contained in a "designated record set" for as long as we maintain your health information. This information is used to make health-related decisions about your care and typically includes professional treatment/progress notes, supplement programs, laboratory reports, prescriptions, and billing/financial records. This request does not include inspection and copying of the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to laws that prohibit access. If you request copies, we may charge you copying and mailing costs.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care. While we consider all requests for restrictions carefully, we are not required to agree to your request.

Right To Request Amendment. If you believe the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have a right to request an amendment for as long as the information is kept by or for S.P.E.A.R. Physical Therapy, PLLC, if we determine the record is inaccurate.

We may deny your request if it is not in the appropriate form or does not include a reason to support the request. In addition we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the information kept by or for S.P.E.A.R. Physical Therapy, PLLC
- Is not part of the information which you would be permitted to inspect or copy
- Is accurate and complete

Right to Request Confidential Communications. You may request that we communicate with you using alternative means or at an alternative location. You may also ask that we mail information to you in a sealed envelope rather than a postcard. While we will consider this request carefully, we are not required to agree to all requests.

Right to Request an Accounting of Disclosures. You have the right to an accounting of disclosures. This is a list of where we have sent your protected health information that does not include disclosures made for treatment, payment, or healthcare operations as described in this notice. Your request must state a time period beginning on or after April 14, 2003, and no more than 6 years from the date of request.

Right To Obtain a Copy of this Notice. You have the right to a paper copy of this notice. You may request a copy of this notice at any time. To obtain a copy of this, please contact the Practice Administrator or his/her designee.

CHANGES TO THIS NOTICE

We reserve the right to change our privacy practices and this notice. We reserve the right to make changed notice effective for health information we already have about you as well as any information we receive in the future. If we change the notice, we will provide each active patient with a new notice. You may also obtain a new notice by calling our office.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with S.P.E.A.R. Physical Therapy, PLLC's Privacy Officer or his/her designee at the address below. No retaliation will occur against you for filing a complaint. All complaints must be submitted in writing. You may also file written complaints with the Secretary of the US Department of Health and Human Services. Please call our office to obtain the correct address for the Secretary.

S.P.E.A.R. Physical Therapy, PLLC
HIPAA Privacy Officer
120 East 56th Street, Suite 1010
New York, NY 10022

OTHER USES OF YOUR HEALTH INFORMATION

Other uses and disclosures of your health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose your health information, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose your health information for the reasons covered by your written authorization. We are unable to take back any disclosures we have already made with your permission and we are required to maintain in our records of the care that we provided to you.

This notice was published on January 5, 2009 and all provisions become effective by Federal Law on April 14, 2003. Our Notice of Privacy Practices remain in effect until modified by S.P.E.A.R. Physical Therapy, PLLC.