

# ***BODY RESTORATION PHYSICAL THERAPY, PLLC***

55 Bryant Ave. Suite 4  
Roslyn, NY 11576  
Office 516-399-2503  
Fax 516-399-2504

PATIENT NAME: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_ APT#: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

SEX: M F O DATE OF BIRTH: \_\_\_\_\_ SS#: \_\_\_\_\_

HOME TEL #: ( ) \_\_\_\_\_ CELL TEL #: ( ) \_\_\_\_\_

WORK TEL #: ( ) \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_

EMAIL : \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ RELATONSHIP: \_\_\_\_\_ TEL #: \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_ TEL #: \_\_\_\_\_

**PRIMARY INSURANCE:** \_\_\_\_\_ TEL # : \_\_\_\_\_

POLICY #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

RELATIONSHIP TO INSURED \_\_\_\_\_ DOB POLICY HOLDER \_\_\_\_\_

NAME OF POLICY HOLDER \_\_\_\_\_ SS # \_\_\_\_\_

**SECONDARY INSURANCE:** \_\_\_\_\_ TEL # : \_\_\_\_\_

POLICY #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

RELATIONSHIP TO INSURED \_\_\_\_\_ DOB POLICY HOLDER \_\_\_\_\_

NAME OF POLICY HOLDER \_\_\_\_\_ SS # \_\_\_\_\_

**YOU MUST SIGN THE AUTHORIZATION BELOW:**

I AUTHORIZE ANY HOLDER OF MEDICAL OR ANY OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMIN. AND THE CENTERS FOR MEDICARE AND MEDICAID OR ITS INTERMEDIARIES FOR CARRIERS, OR TO THE BILLING AGENT OF THE THERAPIST, ANY INFORMATION USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**FOR MEDICARE PATIENTS ONLY:** I UNDERSTAND THAT IF MY SECONDARY INSURANCE CARRIER DOES NOT PAY THE DOCTOR DIRECTLY, IT WILL BE MY RESPONSIBILITY TO DO SO. I AM ALSO RESPONSIBLE FOR MY YEARLY DEDUCTIBLE AND CO-INSURANCE FEES.

I ACKNOWLEDGE RECEIVING A COPY OF BODY RESTORATION PHYSICAL THERAPY, PLLC.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**Assignment of Benefits to Body Restoration Physical Therapy, PLLC**

**Patient Name:**

**Insurance name:**

I request that payment of authorized benefits be made on my behalf to:

**Body Restoration Physical Therapy, PLLC  
55 Bryant Ave Suite 4  
Roslyn, NY 11576**

For services furnished to me by the providers of Body Restoration Physical Therapy, PLLC. I authorize Body Restoration Physical Therapy, PLLC to release appropriate information, medical or otherwise, as provided for by the HIPAA Privacy Rule, to my insurance carrier and/or Centers for Medicare and Medicaid Services and its agents as needed to determine those benefits payable for related services.

**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.

(Check each box and sign at the bottom.)

- ◇ A photocopy of this Assignment shall be considered as affective and valid as the original.
- ◇ I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
- ◇ I authorize the use of this signature on all insurance submissions.
- ◇ I authorize Body Restoration Physical Therapy, PLLC to deposit checks made in my name.
- ◇ I authorize Body Restoration Physical Therapy, PLLC to initiate a complaint to the insurance Commissioner for any reason on my behalf.
- ◇ **I understand it is my responsibility to provide Body Restoration Physical Therapy, PLLC with current and accurate information regarding my medical insurance coverage and referrals when necessary from my primary care physician. I understand failure to do so could result in non-payment by insurance carrier and that any such balances are my responsibility. I understand that I am financially responsible for all charges if not paid by insurance company.**
- ◇ **I understand that I do not have secondary insurance and will be responsible for all monies not paid by primary insurance company.**

I understand that Body Restoration Physical Therapy, PLLC is compliant with HIPAA's Privacy Rule and that they adhere to the rules and regulations with regard to my medical records, or Protected Health Information (PHI). I consent to my PHI being used, disclosed and obtained as described in the Notice of Privacy Practices currently in effect.

I authorize Body Restoration Physical Therapy, PLLC to leave messages on my answering machine at home as needed to notify me of appointments or changes in any of the upcoming visits.

\_\_\_\_\_  
Signature of policyholder

\_\_\_\_\_  
Date



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**NO SHOW/Cancellation Policy**

It is required to give a 48 hours notice to Body Restoration Physical Therapy, PLLC if you are unable to make your appointment time. Please be advised a fee of \$50 will be applied if advanced notice is not given.

**NOTE: In the event of a No Show, all of your future appointment will be automatically cancelled.**

Thank You,

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_