BODY RESTORATION PHYSICAL THERAPY, PLLC

200 S. Service Rd. Suite 209
Roslyn Heights, NY 11577
Office 516-399-2503
Fax 516-908-3999

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 SECRUITY 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 BENFITS 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
200 S. Service Rd Suite 209
Roslyn Heights, NY 11577

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

Patient Name: _____ DOB:_____

Male / Female/ Non-binary
Height _____ Weight _____
Past Medical History:
Circle any that apply-

Arthritis	Osteoporosis	High Blood Pressure
Cholesterol	Cancer	Back Dysfunction
Diabetes	Embolism	Vestibular d/o
Obesity	Thrombosis	Congestive Heat Failure
Dementia	Pneumonia	A-Fib
Depression	COPD	PVD

Other: _____

What is your chief complaint? _____
When did this issue begin? _____
How did this issue begin? _____
Have you received treatment for this before?_____
Have your symptoms: Improved Worsened Remained the same
What are your goals for PT? _____
Pain/Discomfort (circle one): **0 (no pain) 1 2 3 4 5 6 7 8 9 10 (severe pain)**
Location of Pain : **_____**
Type of Pain (circle applicable) : **Sharp Shooting Stabbing Dull/Achy**
Pins/Needles Numbness Pressure Heaviness

Surgeries: _____
_____

Medications/Vitamins/Over-the-counter medication

Name	Dosage	Frequency	Administered (i.e. oral, patch etc.)

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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: _____