ProHealth & Fitness PT OT: Patient Initial Intake Form
Consent for the Release of Medical Information

I authorize any holder of medical or other information about me to release any information needed for this or related medical claim or my care with ProHealth and Fitness PT OT (PH&F PT OT). I hereby agree to the use and disclosure of my personal health information for the purposed noted in PH&F PT OT's *Patient Privacy and Rights* form. In doing so, I release PH&F PT OT from any and all legal liability that may arise from the release of such information. I agree that a copy of this authorization may be used in place of the original.

I understand that I have the right to revoke this consent by notifying PH&F PT OT in writing at any time, except for that action which has already taken place, and no further information will be released without an additional written authorization.

Patient Signature: _____ Date: _____/_____/_____

Insurance Agreement

You have the right for all insurance terms and payments to be explained to you before you begin treatment. **Medicare beneficiaries** should be aware that Medicare's policy allows for approximately 14 visits per calendar year; however, there are some circumstances where this 'threshold' can be extended or visits can be restarted after a period of time. Many insurance companies, including Medicaid and Medicare, often have a maximum number of visits that a patient can use each year, while some are based on medical necessity. If the information you provide on the initial intake paperwork is not accurate, it may result in payment denials from the insurance company and you being responsible for the visit cost. As a patient of PH&F PT OT, you are authorizing that payment of medical insurance benefits be made payable to PH&F PT OT for rehabilitation and/or healthcare services provided that a copy of your authorization may be used in place of the original. You are also responsible for the following:

- Providing us with all of your necessary insurance information
- Notifying us of any changes in your insurance policy or coverage prior to your next visit
- Notifying us of any services/treatment (nursing, physical therapy, occupational therapy, etc.) provided to you in your home by a Home Health Agency or at another facility; your visits with us may not be covered if your insurance if being used for these other services
- Any payments and/or fees not covered by your insurance, including, but not limited to, deductibles, co-pays and co- insurances, unless the Financial Hardship Form is completed and signed by all parties.
- **I authorize PH&F PT OT to send me reminders about my appointments via PHONE or TEXT (circle option)**

I acknowledge that I have received and consent to the policies disclosed in ProHealth and Fitness PT OT's Patient Rights and Privacy form. In addition, I have read and consent to all of the above insurance and payment policies of ProHealth and Fitness PT OT.

Patient Signature: _____ Date: _____/_____/_____

ProHealth & Fitness PT OT Physical/Occupational/APOS
150 West End Avenue #1M New York, New York 10023
180 West End Avenue #1M New York, New York 1002
1041 Third Avenue 2nd Fl. New York, New York 10065
391 East 149th Street #216 Bronx, New York 10455
4915 Broadway #1J New York, New York 10034
T: 212.600. 4781 F: 800.655.3780
www.ProHealthPTOT.com

Date: ____/_____/_____

Patient Name: _____ Patient DOB: ____/____/____

I am requesting that you review my financial situation to see if I qualify for reduction or complete forgoing of my healthcare bill(s) with ProHealth.

I will have or am having problems making payments on my deductible/co-insurance/co-pay because of financial difficulties created by (check what applies):

- ☐ Reduced Income
- ☐ Unemployment
- ☐ Divorce
- ☐ Separation
- ☐ Medical Bills
- ☐ Too Much Debt
- ☐ Death of my Spouse
- ☐ Death of a family member
- ☐ Business Failure
- ☐ Job Relocation
- ☐ Illness
- ☐ Damage to Property
- ☐ Military Service
- ☐ Incarceration
- ☐ Other (Please specify) _____

This difficulty or situation happened on or about this _____/_____/_____

I believe that my situation is (circle one) Temporary / Permanent.

I (print name), _____, state the information provided above to be true and correct to the best of my/our knowledge.

_____
Patient's Signature

I, (printed name of ProHealth representative)_____, accept the above patient's request to (circle): **FORGO REDUCE** all healthcare bills associated with the services provided to the patient, other than payments made to the patient by their insurance company.

_____
Provider's Signature/Provider Representative Signature

James Nussbaum, PT, PhD, SCS, EMT, *Clinical/Research Director*
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DIRECT ACCESS

In New York and most of the United States, patients are now able to be evaluated and treated by a licensed physical therapist without a physician's referral, this is called Direct Access. Some insurance plans may still require you to consult with a physician first, in order to be reimbursed for PT services, so please check with your insurance provider as plans differ.

- Direct access benefits patients in that it allows patients to expedite treatment, saving time and money.
- More information on direct access is available on the American Physical Therapy Association's website: www.apta.org

New York State

1. Treatment can be rendered by a Licensed PT for 10 visits or 30 days, whichever comes first.
2. PT must have practiced PT on a full-time basis for at least 3 years and be 21 years old.
3. PT must provide written notification that services without a referral might not be covered by the patient's health plan and it must state that services might be covered by health plan with a referral. A copy of the signed written notification must be in the patient's file.

ProHealth & Fitness PT OT

1. Prior to your first appointment, we encourage you to check with your insurance provider about the specific requirements and reimbursement policies for your plan
2. At or prior to your initial evaluation, in accordance with State regulations, we will have you sign this form indicating notification regarding direct access and reimbursement.
3. At any time during evaluation and treatment, if we feel your condition is more involved or we are not seeing progress, we will refer you to an appropriate physician.
4. After 10 visits or 30 days (in NY), if further visits are needed, we will refer you to your health care provider for a physical therapy prescription or we can make a suggestion for you if you do not have a physician.
5. If after 10 visits or 30 days, the patient does not have a prescription on file, PT services must stop until a valid prescription is on file.

I understand that I cannot continue to receive physical therapy after my 10th visit or 30 days, without a prescription. I also understand that my insurance policy may have their own rules regarding Direct Access and reimbursement for services rendered.

Date: ___/___/___

Patient's Name: _____ Patient Signature: _____

Physical Therapist: _____ PT signature: _____

ProHealth & Fitness PT OT – Physical and Occupational Therapy
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PATIENT NAME: _____

DATE OF INITIAL SESSION: _____

APOS ID #: _____

I was thoroughly evaluated, fitted for, and have had the APOS shoes calibrated specifically for me and my issues, and:

- I have received the instructions, understand them, and will follow as directed
- I have received the precautions and contraindications and will follow them
- I understand that my doctor will need to sign a prescription for authorizatiion
- I understand that the shoes will be mailed from the APOS warehouse*
  - *Pending full approval authorization if not yet received
- I understand that once delivered, I will return to get my shoes, try on, and begin
- I understand that I am required to participate in 5 follow up (FU) appointments
  - I understand that I need to come to the clinic for my FU appointments
- I understand that my provider/office will call me to schedule my FU appointments
  - If my number changes, I will advise the clinic of the new number
- For any issues with my APOS shoes, it is my responsibility to call immediately

PATIENT NAME: _____ PROVIDER: _____

SIGNATURE: _____ SIGNATURE: _____

OTHER: _____ SUPERVISING PROVIDER: _____

DATE: _____/_____/_____ DATE: _____/_____/_____

FOR OFFICE USE ONLY:

Administrative staff: _____ Adm signature: _____