Stewart Scharfman
Physical Therapy, PC
7914 254TH STREET
FLORAL PARK, NEW YORK 11004
P. 718-343.4262 F. 718.343.1992

DEMOGRAPHIC SHEET

PATIENT INFORMATION

Last Name | **First Name** | **Middle Initial**

Date of Birth | **Social Security Number** | **Gender** ❑ Male ❑ Female

Marital Status ❑ Married ❑ Single ❑ Divorced ❑ Life Partner ❑ Separated ❑ Widowed ❑ Other **Language** other than English

Race (Optional) ❑ Black – Non Hispanic ❑ American Indian/ Alaskan Native ❑ Hispanic ❑ Asian/Pacific Islander ❑ White – Non Hispanic ❑ Other

Home Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Other Phone** ❑ Cell ❑ Pager ❑ Fax

Email Address

Employer | **Position:** | **Employer Phone**

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician | **Referring Physician**

Reason for Visit | Have you seen a Physical Therapist before?

INSURANCE INFORMATION

Primary Insurance: | ID#: | Group #:

Insured: | Relationship:

Secondary Insurance: | ID#: | Group #:

Insured: | Relationship:

IS THIS A WORK RELATED INJURY? | IF SO, PLACE OF INJURY: | Date Of Accident:

IS THIS A RESULT OF AN AUTOMOBILE ACCIDENT? | Date Of Accident:

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Last Name | **First Name** | **Relationship to Patient**

Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Other Phone** ❑ Cell ❑ Pager ❑ Fax

ADDITIONAL INSURANCE INFORMATION

WORKERS COMPENSATION INSURER: | ADJUSTER: | PHONE #: | CASE #:

NO-FAULT CARRIER: | ADJUSTER: | PHONE #: | CLAIM #:

POLICY HOLDER:

Stewart Scharfman Physical Therapy, PC

PATIENT MEDICATION AND HEALTH HISTORY FORM

LIST YOUR PRESCRIBED MEDICATIONS AND OTC DRUGS

MEDICATION NAME	DOSAGE	FREQUENCY	ROUTE

PAST HEALTH HISTORY

LIST ANY ORTHOPEDIC SURGERIES OR SURGERIES RELATED TO YOUR DIAGNOSIS

Year	Reason

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Assignment of Benefits

To Our Patients:

In the past few years, the number of health insurance programs has increased at an amazing rate. Even within a single company, there may be several programs with varying benefits and requirements. We do try our best to confirm your benefits, but it is impossible to absolutely verify the benefits of every patient under every plan.
Therefore, it is **your responsibility** to know:

1: Whether this office is participating in your plan, and what the requirements are in regard to your physical therapy benefit.

2: **Your deductible amount if applicable**.

3: **Your co-payment amount, if applicable.**

These are not our regulations, they are your insurance company's regulations. Unless you follow the guidelines, all or part of your claim may be denied. You will then be responsible for all unpaid charges. Your insurance carrier should have provided a phone number for any questions regarding your coverage. We will do our part, and request that you do yours as well.

I authorize my provider to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

I acknowledge receipt of this information.

Signed: _____ **Date:** _____

Please print name: _____

I have been informed by the staff at Stewart Scharfman Physical Therapy office that all necessary forms will need to be completed by me to help expedite insurance payments and that I take full responsibility to supply all necessary current prescriptions, referrals, and or authorizations at the time of my visit to cover services being rendered to me by this office.

Assignment: I hereby authorize my insurance benefits to be directly paid to this office, and acknowledge that I an financially responsible for any unpaid balance.
In addition, I authorize this office to release any information required to facilitate payment.

Signed: _____ **Date:** _____

If patient has legal guardian, please sign below:

Guardian: _____ **Date**: _____

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HIPAA DISCLOSURE

HIPAA PRIVACY ACT & OFFICE POLICY

ALL INFORMATION SHARED IN THIS TREATMENT IS CONFIDENTIAL EXCEPT IN CIRCUMSTANCES GOVERNED BY LAW. IF YOU WOULD LIKE THIS OFFICE TO SHARE INFORMATION OR CONFER WITH ANOTHER HEALTHCARE PROFESSIONAL OR ATTORNEY, YOU MUST SIGN A "RELEASE OF INFORMATION" FORM.

YOU MAY PERMIT CERTAIN PERSONS TO BE INFORMED OF YOUR CONDITION.

I WOULD LIKE THE FOLLOWING TO BE INFORMED OF MY HEALTH INFORMATION:

NAME:_____ **RELATIONSHIP:**_____

NAME:_____ **RELATIONSHIP:**_____

NAME:_____ **RELATIONSHIP:**_____

PATIENT NAME: PLEASE PRINT:_____

SIGNATURE:_____

DATE:_____

ALL CO-PAYMENTS ARE TO BE PAID AT THE TIME OF SERVICE UNLESS OTHERWISE ARRANGED.
ALL REFERRALS AND PRESCRIPTIONS ARE TO BE THE RESPONSIBILITY OF THE PATIENT.

NO SHOW AND CANCELLATION POLICY:

YOUR VISIT HAS BEEN RESERVED FOR YOU…PLEASE REFER TO YOUR APPOINTMENT PRINT OUT FOR TIMES AND DATES.

NOTICE OF 24 HOURS IS REQUIRED FOR CANCELLATION OF YOUR APPOINTMENT.

IF YOU DO NOT CALL AND DO NOT SHOW UP, YOU WILL BE CHARGED $25

STATEMENT OF UNDERSTANDING:
I HAVE READ AND UNDERSTAND THIS INFORMATION SHEET AND INFORMED CONSENT.
PATIENT NAME:_____ **DATE:**_____

PARENT OR GUARDIAN:_____**DATE:**_____