焦點 FOCUS
手部上肢治療 OCCUPATIONAL THERAPY

Manhattan Office

139 Centre Street, #814
New York, NY 10013
Tel: (212) 966-1288

Queens Office

136-20 38th Avenue, #8A
Flushing, NY 11354
Tel: (718) 559-0912

Patient Information

Date:_____

Last Name:_____ First Name:_____

Date of Birth:_____

SS#:_____

Address: _____

_____

_____

Phone: (Home) _____

(Work) _____

(Cell) _____

Email: _____

Referring Doctor: _____

UPIN# _____

Primary Care Doctor: _____

UPIN# _____

Insurance: _____

ID: _____

Group: _____

Policy Holder: _____

Address: _____

_____

Phone: _____

Workmen's Compensation Insurance/ No fault Insurance:

_____

Claim #:_____

Case Manager Name: _____

Contact #: _____

Date of Accident: _____ Date of Surgery: _____

Notes:

_____

_____

Fax: (212) 537-7244

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INFORMED CONSENT FOR CARE

Focus Occupational Therapy and its personnel respect each patient's rights.

I, _____, do hereby agree and give my consent for Focus Occupational Therapy, P.C. to perform evaluation procedures for determination of appropriate and necessary medical treatment procedures for my physical condition.

_____ _____
Signature of Patient Date

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*To be completed following the evaluation.

_____
Name Patient

I have been advised by Focus Occupational Therapy, P.C. Therapist of the following:

- Diagnosis and evaluation findings
- The proposed course of treatment
- The material risks (if any)
- The expected benefits of treatment
- Reasonable alternatives to the proposed treatment

I also understand that I have the right to refuse treatment or discontinue treatment if I choose, and I will have the risks explained to me as a result of this decision.

These issues are to respect my rights, as a patient, to make an informed decision regarding consent for treatment. I have read and agree, and give my consent for medical treatment to be rendered to me by Focus Occupational Therapy, P.C.

_____ _____
Signature of Patient/ Guardian Date

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NEW PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I, _____, understand that as part of my health care, Focus Occupational Therapy, P.C. originates and maintains paper and/ or electronic records describing my health history, symptoms, examination, and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care & treatment
- A means of communication among the many health professionals who attribute to my care,
- A source of information for applying my diagnosis & surgical information to my bill,
- A means by which 3rd party payers can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality & reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice before signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations

I understand that Focus Occupational Therapy, P.C. reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Focus Occupational Therapy, P.C. change their notice, they will send a copy of any revised notice to the address I have provided.

I wish to have the following restrictions to the use or disclosure of my health information:

_____
_____
_____

I understand that as part of Focus Occupational Therapy, P.C.'s treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and ACCEPT or DECLINE the terms of this consent.
(Circle one)

_____ _____
Signature of Patient/ Guardian Date

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PAYMENT POLICY

Welcome to Focus Occupational Therapy! We appreciate that your physician recommended our practice and that you have chosen us as your rehabilitation specialist. In order to minimize billing problems and keep the cost of providing quality rehabilitation at a reasonable level, please read the section that applies to your billing category carefully. If you have any questions, please do not hesitate to ask for clarification. THANK YOU!

Commercial Insurance: Many insurance carriers pay only a percentage of your rehabilitation costs. This percentage is based on their determination as what is a "usual and customary" fee. You are responsible for any part of the bill that is NOT paid by your insurance company. Special services and supplies that are not covered by insurance are due at the time they are received. In addition to any uncovered charges, you are responsible for your yearly deductible.

Managed Care Plans (HMOs, PPOs, etc.): In many cases, a valid referral from your primary care physician or participating surgeon is required before treatment can be initiated.
Special Services and supplies that are not covered by insurance are due at the time they are received.
You are responsible for your co-payment at the time of each treatment.

Worker's Comp/ No Fault: NYS law prohibits requiring any payment for services rendered while your valid coverage under these policies is in effect. It's your responsibility to provide us with the correct insurance information including the carrier, address, and any claim/ case numbers.

I have read and understand my responsibilities as they apply to payment for services provided by Focus Occupational Therapy, P.C.

_____ _____
Signature of Patient/ Guardian Date

Fax: (212) 537-7244