Patient Express Registration

MBF Rehab PT/OT

Todays Date:

1. Patient Info

Please Fill-Out Entire Form Completely & Legibly.

Last Name _____ First Name _____ Age _____ ❑ Male ❑ Female

Street Address _____ City _____ State _____ ZIP _____

(_____)_____ Home Phone (_____)_____ Cellular ● Email Address (Required in order to watch "New Patient Video")

Occupation _____ Employer Name _____ (_____)_____ Phone #

Emergency Contact Person _____ (_____)_____ Phone # If Patient is a MINOR: Parent/Guardian Name and Signature Here

Social Security #_____ Date of Birth_____/_____/_____ ❑ Single ❑ Married

Work Status: ❑ Currently Employed: ❑ Retired ❑ Disabled (__Total or __Temporary) ❑ Student (__P/T __F/T)

2. My Condition Info

ALL INFO REQUIRED

My injury/ailment is related to . . .

❑ AUTO/PERSONAL INJURY: Date of accident:_____/_____/_____

❑ WORK INJURY: Complete all information below.

Date of injury:_____/_____/_____

Your company HR person name_____

Insurance adjustor name_____

Insurance adjustor PH#_____

❑ NO INJURY: What do you think may have caused it?

I have already had . . .

❑ SURGERY: When and what type?

❑ PHYSICAL THERAPY BEFORE: When and where?

❑ HOME HEALTH Care: Are you still receiving it? __YES __NO

❑ OTHER care: What?

3. Payment Info

(check only one box)

I am paying TODAY by . . .

❑ **INSURANCE** and would like to . . .

__ Have you deal directly with them. I will assign my benefits to you by completing the **"Assignment of Benefits Form"** (Fees may apply in some cases). The following information is required prior to 1st visit.

My coinsurance/copay is $_____

My deductible is $_____

__ Get a 30% discount by paying the entire bill at the time of service. I'll get reimbursement on my own. (Ask the front desk person for details)

❑ **WORKERS COMP** . . .

You must have all info provided under "My Condition...".

❑ **CASH, CHECK, CREDIT** and would like a . . .

__ 30% discount by paying at the time of service.

__ Payment plan and apply for "Financial Hardship"

❑ I have an **ATTORNEY** and would like to . . .

__ Get a 30% discount by paying up front. I'll get reimbursed after my case settles.

__ Wait until my case settles before paying. I will complete the "Attorney Lien" form. Fees may apply.

4. Referral Info

How did you hear about us?

❑ Friend or Family: ❑ Brochure: Give details:

❑ Internet: ❑ Insurance/Directory:

❑ Advertisement: ❑ Other:

❑ Physician/Dentist/Chiropractor/Nurse: Give details below.

Referring Physician/Person's Name _____

City _____ State _____

Phone # _____

❑ I have read and agree to all the policies on the back of this form. Signature_____

Important Company Policies for a Successful Relationship

We strive to provide you the best personalized care available. To make this possible we adhere to a set of very important guidelines. Please read them carefully, initial all the boxes, and indicate your agreement by signing on the other side of this form (bottom).

Initial All Boxes

☐ **Late Policy "10-minutes"**
Being late by more than 10 minutes will require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations are unpredictable. We do not allow appointment overlap because this undeservedly compromises the care of another patient.

☐ **24-Hour Advance Notice Fee**
If you wish to change or cancel an appointment we require a minimum ***24-hour advance notice***. Anything less will result in a ***$10 fee*** charged to your account. It costs us money to make appointments available to you. Whether you attend or not we still accrue the expenses (for staff wages, rent, etc.). We don't charge you the actual cost for that appointment but rather a mere ***$10 fee***. We do NOT make money with this charge; it's only to act as a deterrent from making last minute changes. Advance notice allows someone else (who needs it) time to reserve it in place of you. Please be courteous and responsible. Thank you.

☐ **Copays are due upon arrival**
If you happen to forget your wallet or checkbook we may still be able to see you upon completion of an "Extension Request" form. This is a "promise-to-pay" form and carries a minimal fee that allows you to keep your appointment.

☐ **No-shows are bad**
If you fail to show for an appointment without notice all future appointments will be removed and a ***$10 fee*** assessed to your account. You may re-schedule appointments again on a "first come, first serve basis".

☐ **Cell phones must be shut OFF or silent.**
We realize emergencies may arise and therefore allow you to carry your cell phone during your session, however, please be courteous and set to silent mode or turn off. Thank you.

☐ **Children requiring supervision are NOT allowed to attend sessions with you.**
Unless your facility offers child care services, you may not bring children who require supervision with you to your appointment. If your child does not require supervision and is capable of waiting for you quietly then you may bring them. If any disturbance is caused to other patients or staff members you may be asked to terminate your session early and attend to your child.

☐ **Financial Hardship**
If you are experiencing financial difficulties and are unable to afford the cost of our services we have a "Financial Hardship Form" which may be filled-out. If you quality for financial assistance according to the Federal guidelines, we may legally assist you by waiving or discounting your (patient responsibility) portions of the bill. Ask the front desk person for assistance.

☐ **Important Notice from the Federal Government:**
"It is unlawful to routinely avoid paying your copay, deductible or coinsurance payments . . . even if your doctor allows it. Unless you complete a "Financial Hardship" form and qualify for financial assistance under Federal Standards, you may NOT routinely evade paying your responsibility portions for medical care as outlined in your insurance plan even if your doctor allows it. You both may be charged for breaking the law. This includes services deemed as "professional courtesy" and "TWIP's - Take what insurance pays". Failure to comply places you in violation of the following laws: Federal False Claims Act, Federal Anti-Kickback Statute, Federal Insurance Fraud Laws, State Insurance Fraud Laws. Failure to comply may result in civil money penalties (CMP) in accordance with the new provision section 1128 A(a)(5) of the Health Insurance Portability and Accountability Act of 1996 [section 231(h) of HIPAA]. Exceptional cases do apply. Please see contact info for more information. Office of Inspector General, Department of Health and Human Services. Contact by by phone: 202 619-1343, by fax: 202 260-8512, by email: paffairs@oig.hhs.gov, by mail: Office of Inspector General, Office of Public Affairs, Department of Health and Human Services, Room 5541 Cohen Building, 333 Independence Avenue, S.W., Washington, D.C. 20201, Joel Schaer, Office of Counsel to the Inspector General, 202 619-0089."

We look forward to building a successful relationship with you that lasts a lifetime!

Assignment of My Benefits

IMPORTANT: All information must be **completed** or we will NOT be able to do the courtesy of dealing directly with your insurance.

1. Benefit Info

What is your deductible amount? $_____ and Coinsurance %_____ (for the services you are seeking)

Are there any maximums?

If you don't know this information, call the "800" number on your insurance card. The front desk person may be able assist you.

2. Policy Info

Patient Name:_____ ID #_____ DOB_____

Insurance Policy 1 Name/Number/Group # (if applicable)_____

_____

***IS PATIENT INSURED THROUGH SOMEONE ELSE'S POLICY?** Give their info here: (otherwise, skip this portion)

- Policyholder Name_____ Date of Birth_____ SSN_____
- Address (if different than Patient)_____
- Relationship to Patient: __ Spouse __ Parent __ Other: _____
- Employer _____ Ph#_____ Claim #_____
- Employer Address _____

Insurance Policy 2 Name/Number/Group # (if applicable)_____

_____

I hereby instruct and direct _____ insurance company to **pay by check made out to the "Healthcare Provider" to the right and mailed to** the address on the right (not mine). If my/this current policy prohibits direct payment to doctor/therapist, I hereby also instruct and direct you to make out the check to me and mail it to the above address for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

Healthcare Provider info:

MBF Rehab PT/OT PLLC
156-11 Aguilar Ave Suite 1018
Fresh Meadows, NY 11367
(718) 380-4750
www.MBFmethod.com

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 effective 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 the "Healthcare Provider" named above to deposit checks made in my name.
- ☐ I authorize the "Healthcare Provider" named above to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- ☐ I understand that I am financially responsible for all charges whether or not paid by insurance.

Dated this _____ day of _____, 20_____.

_____	_____	_____
Signature of Policyholder	Witness	Signature of Claimant, if other than Policyholder