Today's Date:_____

Patient Information

Patient's Name: _____ Social Security: ____-____-_____

Primary Insurance: _____ Copay: $_____ (on back of card)

Secondary Insurance: _____

Home Phone: (____) _____-_____ Other (optional): (____) _____-_____

Cell Phone: (____) _____-_____ Email: _____@_____

Patient completes this section:

What type of therapy are you seeking? ☐ Physical (PT) ☐ Occupational (OT) ☐ Speech (SLP)

Why are you seeking therapy? (please include date of occurrence if applicable)

_____

_____

Were you treated with any therapy earlier this year? ☐ Yes ☐ No

If 'Yes', please describe when and why:

_____

Do you have any medical or surgical history? ☐ Yes ☐ No

If 'Yes', please indicate:

_____

Do you currently take any medications? ☐ Yes ☐ No

If 'Yes', please indicate which:

_____

Have you been treated at Suki's Place before? ☐ Yes ☐ No

If no, how did you hear about Suki's Place? _____

When are your convenient/ inconvenient times for appointment?

_____

PLEASE PROVIDE THE OFFICE WITH YOUR PERSCRIPTION AND INSURANCE CARD(S) ALONG WITH THIS FORM

INSURANCE CLAIM FORM

1. PATIENT NAME:		2. PATIENT DOB:
		/ /
3. PATIENT ADDRESS:		
CITY:	STATE:	ZIP:

4. IS PATIENT CONDITION RELATED TO:		
EMPLOYMENT?	☐ YES	☐ NO
AUTO ACCIDENT?	☐ YES	☐ NO
OTHER ACCIDENT?	☐ YES	☐ NO

5. PATIENT RELATIONSHIP TO INSURED:			
☐ SELF	☐ SPOUSE	☐ CHILD	☐ OTHER

IF ANSWERED 'SELF' TO QUESTION #5, DO NOT CONTINUE BELOW.

6. INSURED'S NAME:		6a. INSURED'S DOB:
		/ /
6b. INSURED'S ADDRESS:		
CITY:	STATE:	ZIP:
6c. INSURED'S PHONE:		
HOME: (_____) _____ - _____		MOBILE: (_____) _____-_____

7. OTHER INSURED'S NAME:		7a. OTHER INSURED'S DOB:
		/ /
7b. OTHER INSURED'S ADDRESS:		
CITY:	STATE:	ZIP:
7c. OTHER INSURED'S PHONE:		
HOME: (_____) _____ - _____		MOBILE: (_____) _____-_____

Shair Home Care Therapy
473 FDR Drive NY, NY 10002
212-475-2000

Patient Consent and Financial Responsibility

Shair Home Care Therapy has been asked by your physician to provide physical therapy evaluation and treatment services. Please read, sign and date this form, to confirm your understanding and your agreement to its content.

Informed Consent - My physician has prescribed, and Shair Home Care Therapy has designed, a plan of care to provide physical therapy to address one or more of my medical conditions. I request and agree to receive the services of Shair Home Care Therapy as recommended in the plan of care designed by my therapist and prescribed by my physician.

HIPPAA Acknowledgement - I authorize Shair Home Care Therapy to release to appropriate agencies my protected health information, for purposes of treatment or payment. The Statement of Privacy Policy of Shair Home Care Therapy is available upon request and I can review it with my therapist to learn how Shair Home Care Therapy may use and disclose the protected health information, prior to signing this document. I may revoke this agreement in writing by proper advance notification to Shair Home Care Therapy

Statement of Financial Responsibility - I authorize direct payment to Shair Home Care Therapy from my primary insurance carrier as well as from my secondary insurance carrier (if any). If my primary insurance carrier does not cover my full bill, I will be billed for the uncovered portion, and I acknowledge my personal responsibility for that balance, to the extent permitted by law. Any uncovered portion may include primary and secondary insurance deductibles, co-pays, and any other out of pocket expenses due to my insurance policy. I agree to forward any insurance payments that I receive from my insurance carriers directly to Shair Home Care Therapy. I am obligated to inform Shair Home Care Therapy of any changes in my insurance coverage.

Patient Signature:_____ Date: _____

Print Name:_____