



157-02 Crossbay Blvd, Suite 202 Howard Beach, NY 11414 P: (718) 835-0100, F: (718) 848-2233

Today's date:

(Please Print Clearly)

PATIENT INFORMATION

Last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
E-mail :			SSN #:	Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Street address:		Apt.#	Home ph.# ()		Cell ph#()		
P.O. box:		City:		State:		ZIP Code:	
Occupation:		Employer:			Employer ph# ()		

Current Work Status: Full Time Part time Full time w/Limitations Part time w/Limitations Not Currently Employed Retired Disability

Race: (please Check one) American Indian Asian Black or African American Chinese Hispanic Other Pacific Island White Other _____

Ethnicity: (please Check one) African Asian Chinese Caucasian French German Hispanic / Latino Irish Jewish Italian Polish Russian Other _____

Primary Language: (please Check one) English Spanish French Italian German Russian Chinese Japanese Other _____

***Whom may we thank for referring you?** doctors office , if so what Dr: _____ friend/family
 Insurance company internet law office _____ other: _____

Primary Care Physician: Name: _____ Last time seen: _____

Address/ Phone: _____

Pharmacy Information: (We send your prescriptions directly to your pharmacy so there is less waiting time for you.)

Name: _____ Phone: _____

Address: _____ State: _____ Zip: _____

Emergency Contact: Name: _____ Relationship: _____

Phone: _____ Work Phone: _____ Email: _____

I Certify that all the above and below information is correct.

_____ Signature of Patient or Responsible party
 _____ Relationship to Beneficiary
 _____ Date



Insurance Certification

It is the patient's responsibility to inform the office about any changes in your insurance, address or telephone number. You are responsible to bring all appropriate insurance referrals & authorizations, if such required. **Failure to do so will result in financial responsibility for the services provided.**

Insurance assignment and release

I certify that I have insurance coverage with _____ and assign directly to Dr. **Benjamin Bieber** / **Dr. Debra Weinstock** / **Cross Bay Physical Therapy** (circle one) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services

MEDICARE/MEDICAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits be made on my behalf to **Dr. Benjamin Bieber** / **Dr. Debra Weinstock** / **Cross Bay Physical Therapy** (circle one) for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer and their agents any information needed to determine these benefits for related services.

Patient Name (print name): _____ Date: _____

Signature: _____ Date: _____
patient or responsible party



Prescription Agreement Form

The purpose of this agreement is to protect your access to controlled substances and protect our ability to prescribe for you.

The long-term use of such substances as opioids (narcotics, analgesics), benzodiazepine tranquilizers and barbiturate sedatives is controversial because of uncertainty regarding, the extent to which they provide long term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of the risk is not certain. Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the physician whose signature appears below to consider the initial or continued prescription of a controlled substance to treat your chronic pain.

1. All controlled substances must come from the physician whose signature appears below or, during his or her absence, by the covering physician, unless specific authorization is obtained for an exception. (Multiple sources can lead to untoward drug interactions or poor coordination of treatment.)
2. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is:

* _____ **Phone:** _____

3. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.
4. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacist or other professionals who provide your health care for purposes of maintaining accountability.
5. You may not share, sell or otherwise permit others to have access to these medications.
6. These drugs should not be stopped abruptly, as an abstinence syndrome will likely develop.
7. Unannounced urine or serum toxicology screens may be requested, and your cooperation is required. Presence of unauthorized substances may prompt referral for assessment for addictive disorder.
8. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them.

X _____ Date _____
Signature of patient or responsible party

***Confidential* MEDICAL HISTORY FORM (continued)**

Which of the following conditions are you currently being treated or have been treated for in the past (please check)

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Heart disease / Murmur / Angina | <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Liver problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Radiculopathy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> HIV/Aids |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Neuritis/Neuroma | <input type="checkbox"/> Lung problems | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Palpations/Pacemaker | <input type="checkbox"/> Stroke | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Poor circulation/Vascular disease | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Shortness of breathe | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anemia or blood problems | <input type="checkbox"/> Spinal stenosis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bowel Disease |
| <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Diverticulosis |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Gout | <input type="checkbox"/> Pancreas Problems | <input type="checkbox"/> Prostate |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Lupus | <input type="checkbox"/> Colitis | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Falling / History of a fall | <input type="checkbox"/> Lyme disease | <input type="checkbox"/> Current Weight Gain/Loss | <input type="checkbox"/> GI upset/heartburn |
| <input type="checkbox"/> Walks with a cane or walker | <input type="checkbox"/> Polymyalgia rheumatica | <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Ulcer stomach |
| <input type="checkbox"/> Joint Pain _____ | <input type="checkbox"/> Raynaud's syndrome | <input type="checkbox"/> Swelling | <input type="checkbox"/> Kidney problem |
| <input type="checkbox"/> Joint Aches/Locking _____ | <input type="checkbox"/> Scleroderma | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Bladder |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Sojourn's disease | <input type="checkbox"/> Eye disorder / Glaucoma | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Unstable walking | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Nose problems | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Malaise | <input type="checkbox"/> Athletes foot | <input type="checkbox"/> Irritability/Mood Change | <input type="checkbox"/> Recent Fever |
| <input type="checkbox"/> Stiffness | <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Sleep Disturbance | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Pins and Needles/Numbness | <input type="checkbox"/> Bruises | <input type="checkbox"/> Sweating | <input type="checkbox"/> |
| <input type="checkbox"/> Neuropathy | <input type="checkbox"/> fungus nails | | |
| <input type="checkbox"/> Neurologic problems | <input type="checkbox"/> Ulcers- skin | <input type="checkbox"/> Dizziness | |
| <input type="checkbox"/> OTHER serious illness _____ | | | |

Is there any Family History of the above conditions? If so, please list with family member who has or had the condition:

Social History:

Do you smoke? Yes No If yes, how many packs per day: _____ How many Years? _____

Treatment Consent:

I hereby consent and give my permission to the doctor (doctor's assistant or designated replacement) to administer and perform procedures upon me as the doctor deems necessary.

SIGNATURE: X _____ DATE: _____



FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

REGARDING INSURANCE:

We accept assignment of insurance under most plans. We cannot bill your insurance unless you give us your insurance information and an original claim form if necessary. Your insurance policy is a contract between you and your insurance company. We are not party to the contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services or not considered reasonable and necessary under the Medicare Program and/ or other medical insurance. The balance due is your responsibility whether your insurance company pays or not.

REGARDING REFERRALS:

It is your responsibility to obtain all referral forms required by your insurance company. Please be aware that if you choose to be seen by our doctor under an out of network insurance plan, you assume liability for the difference in coverage benefits.

COPAYS:

You will be expected to pay your copay at the time of your appointment. If you are unable to pay, you will be required to reschedule your appointment. We accept cash, checks, money orders, Visa, MasterCard and Discover.

USUAL AND CUSTOMARY RATES:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

REGARDING PATIENTS WITH NO INSURANCE:

Payment is due at the time of service.

REGARDING PATIENTS WITH MEDICARE:

We will file all charges with Medicare and your supplemental insurance if applicable. If you do not have supplemental insurance, you are expected to pay for the 20% not paid by Medicare, or any deductible that has not been met at the time of your appointment.

MINOR PATIENTS:

Patients under the age of 18 **must** have a parent and/or guardian accompany them to our office before treatment can be rendered. The accompanying adult of minor and /or the parents (or guardians of the minor) are responsible for full payment.

MISSED APPOINTMENTS:

We require that you call at least 24 hours in advance. Appointments that are missed will accrue a fee of \$50.00 that will be charged to the patient's account.

It is always your responsibility to be sure that your account is settled.

I hereby authorize the release of any information necessary to file a claim with my insurance company and assign benefits to Benjamin Bieber, MD / Debra Weinstock, DPM / Cross Bay Physical Therapy.

I acknowledge that I have read the billing policies listed above, agree, and understand my responsibilities as a patient at Benjamin Bieber, MD / Debra Weinstock, DPM / Cross Bay Physical Therapy. I also understand that if I fail to pay charges, I imply discontinuation of medical services.

Signature (patient or responsible party)
entered by _____ reviewed by _____ Date: _____

Date

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