PATIENT INFORMATION

FIRST NAME _____ MI. ___ LAST NAME _____ DATE OF BIRTH ____/____/____

ADDRESS_____ CITY_____ STATE _____ ZIP _____

PRIMARY PHONE# _____ SECONDARY PHONE# _____ SOCIAL SECURITY #_____-____-_____

REFERRING PHYSICIAN: _____ PRIMARY PHYSICIAN:_____

DATE OF ILLNESS/INJURY: _____/_____/_____ WERE YOU PREVIOUSLY UNDER THE CARE OF A PHYSICAL THERAPIST FOR THIS OR ANY OTHER CONDITION THIS YEAR? (YES/NO*) If "YES" please provide details: _____

PRIMARY INSURANCE

(CIRCLE ONE) MAJOR MEDICAL HMO WORK.COMP* NO-FAULT‡ MEDICARE

(If your primary insurance is MEDICARE, you may NOT be covered here if you receive any home care services. If you are receiving ANY type of home care treatment, you will be liable for all charges.)

INSURANCE COMPANY NAME: _____

ID#: _____GROUP# _____

NAME OF PRIMARY SUBSCRIBER: _____ RELATION TO PATIENT: _____

* WORKER'S COMP (REQUIRED INFO): DATE OF INJURY: _____/_____/_____ CARRIER CASE #_____

W.C.B CASE#_____ ARE YOU CURRENTLY WORKING? Y/N

‡ NO-FAULT (REQUIRED INFO): DATE OF INJURY: _____/_____/_____ POLICY # _____

SECONDARY INSURANCE

INSURANCE COMPANY NAME: _____

ID#: _____GROUP# _____

NAME OF PRIMARY SUBSCRIBER: _____ RELATION TO PATIENT: _____

***************************PLEASE SIGN BELOW – *BOTH SECTIONS MUST BE SIGNED************************

I GIVE PERMISSION TO SUSAN E. BENNETT, PT PC TO RELEASE INFORMATION TO MY INSURANCE COMPANY. I AUTHORIZE PAYMENT DIRECTLY TO SUSAN E. BENNETT, PT PC FOR THE TREATMENT I RECEIVE.

SIGNATURE REQUIRED _____ DATE _____/ _____/ _____

(Signature of Patient or Guardian if patient if under 18)

IMPORTANT! PLEASE READ!

I agree I am primarily liable for all charges for services rendered by Susan E Bennett, PT PC and agree to pay all amounts not paid by my insurance carrier(s), for any reason. If I am claiming coverage under Worker's Compensation/No-Fault laws, I understand I am fully liable if such coverage is subsequently denied. I agree to supply major medical information in anticipation of such a denial. If I am claiming coverage through an HMO, I understand I am responsible for obtaining a valid referral prior to treatment and that treatment without such a referral will cause me to be personally liable for today's charges as well as future charges.

If I make payment to Susan E Bennett, PT PC in cash, I understand that I must obtain a receipt and retain this receipt for at least three months. If I do not provide payment when it is due, I agree to pay all reasonable attorney's or collection costs Susan E Bennett, PT PC may incur to collect such past due amounts. I understand that if I am referred to collection, a fee in addition to my outstanding balance will be applied to my account. I accept that this fee will be 40% for outstanding balances under $100 and 33.3% for balances over $100 (minimum fee of $10.00). I also understand that **COPAYS ARE DUE AT THE TIME OF TREATMENT. IF A SECOND STATEMENT IS REQUIRED, A $5.00 BILLING FEE WILL BE ADDED TO YOUR ACCOUNT AND THAT CANCELLATIONS REQUIRE AT LEAST 24 HOURS ADVANCE NOTICE.**

A $25.00 fee will be charged for any cancellation made within less than 24 hours and for any missed appointment without notice.

SIGNATURE REQUIRED _____ DATE _____/ _____/ ____

(Signature of Patient or Guardian if patient is under 18)

Susan E. Bennett PT PC HISTORY SCREEN

Name: (Last, First)	DOB: (MM/DD/YYY):	Age:	Gender Identity (check): □ Male □ Female □ Transgender □ Other □ Prefer not to disclose
What is your primary problem?	When did it start?	Within the last 6 weeks, check if ○ You were hospitalized ○ You received home care.	
What was the cause of your injury?	□ Work Injury □ Auto Accident □ Onset over time □ Unknown □ Other-Specify		
Are you working at this time?	□ Yes – Full Time □ Yes – Part Time □ No □ Not Applicable/ Not employed □ Retired	Your occupation:	
Have you had any formal therapy for this condition in the past?	□ Yes If Yes, When? Where? □ No		
What do you hope to gain by attending therapy?			
Rate your pain or symptom severity on a scale of 0 to 10.	NO PAIN 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 WORSE PAIN		
In case of an emergency, who can we contact?	Name:	Phone #:	Relationship:

GENERAL HEALTH:
- ☐ I AM PREGNANT
- ☐ EXCELLENT
- ☐ GOOD
- ☐ FAIR
- ☐ POOR

ALLERGIES TO MEDICATIONS:
- ☐ NO DRUG ALLERGIES
- ☐ ALLERGY TO PENICILLIN
- ☐ ALLERGY TO SULFA DRUGS
- ☐ _____

SOCIAL HISTORY:
ALCOHOL:
☐ NONE ☐ LIGHT ☐ HEAVY

TOBACCO:
☐ NONE ☐ LIGHT ☐ HEAVY

OTHER COMMENTS:
HAVE YOU RECENTLY HAD:
- ☐ FEVER
- ☐ CHILLS
- ☐ MALAISE/FATIGUE
- ☐ UNEXPECTED WEIGHT LOSS

EARS:
- ☐ NO PROBLEMS
- ☐ IMPAIRED HEARING
- ☐ HEARING AID
- ☐ RINGING OR BUZZING
- ☐ OTHER _____

HEART:
- ☐ NO HEART PROBLEMS
- ☐ CHEST PAIN
- ☐ HISTORY OF HEART ATTACK
- ☐ CORONARY ARTERY DISEASE
- ☐ HIGH BLOOD PRESSURE
- ☐ LEG/ANKLE SWELLING
- ☐ IRREGULAR HEARTBEAT
- ☐ PACEMAKER
- ☐ OTHER _____

NEUROLOGICAL:
- ☐ NO PROBLEMS
- ☐ HEADACHES
- ☐ DEPRESSION
- ☐ ANXIETY
- ☐ HEAD INJURY
- ☐ DIZZINESS
- ☐ STROKE
- ☐ NUMBNESS
- ☐ SEIZURES
- ☐ PARKINSON'S
- ☐ MULTIPLE SCLEROSIS
- ☐ PERIPHERAL NEUROPATHY
- ☐ OTHER _____

EYES:
- ☐ NO PROBLEMS
- ☐ IMPAIRED VISION
- ☐ CATARACT
- ☐ GLASSES/CONTACTS
- ☐ GLAUCOMA
- ☐ MACULAR DEGENERATION
- ☐ OTHER _____

GASTRO-INTESTINAL:
- ☐ NO PROBLEMS
- ☐ REFLUX/HEARTBURN
- ☐ HIATAL HERNIA
- ☐ ESOPHAGUS DILATION
- ☐ FEEDING TUBE
- ☐ BARRAT'S ESOPHAGUS
- ☐ ZENKER'S DIVERTICULUM
- ☐ OTHER _____

MUSCULO-SKELETAL:
- ☐ BACK PAIN
- ☐ NECK PAIN
- ☐ ARTHRITIS
- ☐ FRACTURES
- ☐ MAJOR JOINT PROBLEMS

METABOLIC DISORDERS:
- ☐ NO PROBLEMS
- ☐ THYROID DISEASE
- ☐ DIABETES
- ☐ LOW BLOOD SUGAR
- ☐ OSTEOPOROSIS
- ☐ OTHER _____

NOSE/THROAT:
- ☐ NO PROBLEMS
- ☐ SINUS PROBLEMS
- ☐ DIFFICULTY SWALLOWING
- ☐ ASTHMA
- ☐ WHEEZING
- ☐ SHORTNESS OF BREATH
- ☐ PAIN ON BREATHING
- ☐ COPD
- ☐ OTHER _____

URINARY SYSTEM:
- ☐ NO PROBLEMS
- ☐ PAINFUL/DIFFICULT URINATION
- ☐ FREQUENT URINATION
- ☐ HISTORY OF KIDNEY DISEASE
- ☐ BLOOD IN URINE
- ☐ OTHER

SURGICAL HISTORY (Describe):
- ☐ NO PAST SURGERIES
- ☐ SHOULDER/ELBOW
- ☐ WRIST/HAND
- ☐ HIP
- ☐ KNEE
- ☐ FOOT/ANKLE
- ☐ HEART BYPASS
- ☐ LOW BACK
- ☐ HEAD/BRAIN
- ☐ CATARACT
- ☐ NECK
- ☐ THYROID
- ☐ STOMACH
- ☐ GALL BLADDER
- ☐ BOWEL
- ☐ KIDNEY
- ☐ PROSTATE
- ☐ HYSTERECTOMY
- ☐ OTHER _____

CANCER HISTORY:
- ☐ NO PROBLEMS
- ☐ YES, I HAVE A HISTORY OF CANCER. DETAILS: _____
  _____

Susan E. Bennett, PT PC
Phone: (716) 803-8220 Fax: (716) 874-1458

PATIENT NAME: _____ D.O.B: _____

MEDICATION	PURPOSE	DOSAGE	FREQUENCY	ROUTE (oral, sublingual, topical, injection)

FOR OFFICE USE ONLY:

Reviewed by: _____ Date: _____

Bennett Rehabilitation Institute
Susan Bennett, PT and Associates
Kenmore, Williamsville, Orchard Park
Phone: (716) 803-8220 Fax: (716) 874-1458

Fall Risk Questionnaire		
Please Check "Yes" or "No" for Each Statement Below	**Yes**	**No**
I have fallen in the past year.		
I use or have been advised to use a cane or walker to get around safely.		
Sometimes I feel unsteady when I am walking.		
I steady myself by holding onto furniture when walking at home.		
I am worried about falling.		
I need to push with my hands to stand up from a chair.		
I have some trouble stepping up onto a curb.		
I often have to rush to the toilet.		
I have lost some feeling in my feet.		
I take medicine that sometimes makes me feel light-headed or more tired than usual.		
I take medicine to help me sleep or improve my mood.		
I often feel sad or depressed.		
Total	**/12**	

	Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1	Feeling nervous, anxious or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless that it is hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid as if something awful might happen	0	1	2	3
		Total score:			

SUSAN E. BENNETT, PT PC INSURANCE INFORMATION PLEASE READ SIGN. IF REQUESTED, A COPY WILL BE PROVIDED TO YOU.

HMO

- Referrals: If you have an HMO type policy, you should determine if your plan requires a referral from your referring physician. If a referral is required, and you fail to obtain one, you will be personally responsible for our charges.
- HMO policies often place a limit on the number of physical therapy treatments they will cover. Please know the limits of your coverage. You will be held responsible for fees incurred beyond the limits of your coverage. It is important to let us know if you have had any other previous physical therapy treatments at any other clinics this year so that we may calculate your insurance coverage accurately.
- Copays: If your HMO policy requires that you pay a copay, it is due at the time of treatment.

MEDICARE

- Home Health Care: **Medicare will not cover home health care services AND physical therapy treatments concurrently.** If you choose to continue home health care services and physical therapy treatment, you will be responsible for our charges.
- Deductible and Coinsurance: The 2024 deductible for Medicare Part B is $240.00. After your deductible is met, you typically pay 20% of the Medicare approved amount for outpatient therapy. The Medicare 2024 "therapy cap" is $2330.00 that they will pay for. This is physical therapy and speech-language pathology services combined.
- You are required to have a script for physical therapy from a physician to claim coverage from Medicare.

MEDICAID

We are not approved providers for Medicaid.

BCBS-THERAMATRIX/ BCBS - GM RETIREE

We are not participating providers with these insurances. They will not pay for treatment at our offices.

AETNA & UNITED HEALTHCARE AND OTHERS

Although we will see patients with all types of insurances, we may not be participating providers with your insurance. In some cases, we are considered "Out-of-Network" providers. You must check with your insurance carrier to determine how much of our charges, if any, will be covered. We may not accept your insurance benefits as payment in full, so a 20% copay must be paid at the time of treatment. This will be applied against any balance you may owe.

NO-FAULT & WORKERS' COMPENSATION

- NO-FAULT: For patients claiming coverage under No-Fault Insurance, we will bill your No-Fault carrier. However, if they do not pay, you will be liable for our charges.
- WORKERS' COMPENSATION: Patients claiming through Workers' Compensation Insurance must provide all necessary information to our office so that we may submit claims to your carrier. We will bill Workers' Compensation as required by law. However, the Workers' Compensation Board may rule that you may not collect Workers' Compensation, in which case you will be liable for our charges.
- OTHER TREATMENTS: Please note that most No-Fault and Workers' Compensation carriers will not cover two treatments on one day. For example, if you are seeing a chiropractor, your carrier may not pay for a treatment if it took place on the same day as your physical therapy treatment.
- HEALTH INSURANCE: If you have health insurance, we require that you provide this information to us at the time of your first treatment, so that we may acquire authorizations and submit claims if necessary.

I have read and understand the above notice:

_____ _____

Signature of Patient or Guardian **Date**

NOTICES OF PRIVACY PRACTICES REGARDING PATIENT HEALTH INFORMATION

WE ARE GIVING YOU THIS NOTICE BECAUSE FEDERAL REGULATIONS (HIPAA) REQUIRE THAT WE ADVISE YOU OF OUR PRIVACY PRACTICES WITH REGARD TO YOUR HEALTH INFORMATION.

OUR PRACTICE HAS ALWAYS BEEN COMMITTED TO MAINTAINING THE PRIVACY OF YOUR PROTECTED HEALTH INFORMATION AND WILL CONTINUE TO DO SO. THIS NOTICE DETAILS YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION AND HOW YOU MAY OBTAIN ACCESS TO IT, IF DESIRED. THIS NOTICE ALSO DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY SUSAN E. BENNETT, PT PC TO CARRY OUT YOUR TREATMENT, OBTAIN PAYMENT, AND PERFORM THE HEALTH CARE OPERATIONS OF THE PRACTICE AND FOR OTHER PURPOSES PERMITTED OR REQUIRED BY LAW. PLEASE READ IT CAREFULLY.

YOUR INDIVIDUAL RIGHTS.

You have certain rights under the HIPAA federal privacy standards. These include:

- The right to receive a printed copy of this notice.
- The right to inspect and copy your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to amend or submit corrections to your protected health information.
- The right to receive a written accounting of how and to whom your protected health information has been disclosed.
- The right to request restrictions on the use and disclosure of your protected health information.

SUSAN E. BENNETT, PT PC DUTIES.

We are required by law to maintain the privacy of your protected information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

ISSUES AND DISCLOSURES.

The examples given are not meant to include all possible types of use and/or disclosure

TREATMENT.

Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluation your health, diagnosing medical conditions and providing treatment. For example – results of physical therapy tests and procedures will be available in medical record to all health professionals who may provide treatment for you or who may be consulted by staff members.

PAYMENT.

Your health information may be used to seek payment from your health plan, from other sources of coverage such as automobile insurer or from credit card companies that you may use to pay for services. For example – Your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated. Information may also be given to collection agencies for pursuit of payment in the event you do not pay your charges as required.

HEALTH CARE OPERATIONS.

Your health information may be used as necessary to support the day-to-day activities and management of Susan E. Bennett, PT PC. For example – Information on the services you received may be used to do budgeting and financial reporting, and activities to evaluate and promote quality. Your information may also be provided to a billing or transcription services.

HEALTH ENFORCEMENT.

Your health information may be disclosed to law enforcement agencies to support government audit inspections, or facilitate law-enforcement investigations, and to comply with government-mandated reporting.

HEALTH REPORTING.

Your health information may be disclosed to public health agencies as required by law. For example – if we become required to report certain communicable diseases to this state's public health department.

ADDITIONAL INFORMATION.

Appointment reminders. Your health information may be used by our staff to send appointment reminders or make telephone follow-up calls. Our practice utilizes a sign in sheet. Your name will be called in the waiting room when your appointment is ready or on the public address system if you are needed at the front desk.

Continued----------

OTHER USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION.

Disclosure of your health information or its use for any purpose other than those listed on the preceding page requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

REQUESTS TO INSPECT YOUR PROTECTED HEALTH INFORMATION.

You may generally inspect or request copies of the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contracting the Privacy Officer. Your request will be a fee for copied records.

COMPLAINTS.

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Officer
Susan E. Bennett, PT PC
3352 Southwestern Blvd.
Orchard Park, NY 14127

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

CONTACT PERSON.

The name and address of the person you may contact for further information concerning our privacy practices is as shown above.

EFFECTIVE DATE.

This notice is effective on or after January 1, 2006.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES.

As permitted by law, Susan E. Bennett, PT PC reserves the right to amend or modify the privacy practices outlined in this notice. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any visit. The revised policies and practices will be applied to all protected health information we maintain.

SIGNATURE
I HAVE RECEIVED A COPY OF THIS NOTICE OF PRIVACY PRACTICES FOR SUSAN E. BENNETT, PT PC

Name of Patient (print or type)

Signature of Patient

Date

Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient

Bennett Rehabilitation Institute
Susan Bennett, PT and Associates

Kenmore Office	Orchard Park Office	Williamsville Office
2075 Sheridan Drive, Suite D Kenmore, NY 14223	3352 Southwestern Blvd Orchard Park, NY 1417	2821 Wehrle Drive, Suite 5 Williamsville, NY 14221

24-HOUR APPOINTMENT CANCELLATION POLICY

For cancellations please call:

(716) 803-8220

(A message is satisfactory for compliance)

Thank you for making **Susan E. Bennett, PT PC** your choice for physical therapy services. Our therapists are dedicated to providing comprehensive care to help you meet your rehabilitation and wellness goals. Failing to cancel your appointment well in advance or not showing up for an appointment hinders our ability to provide the best possible care for all our patients. Out of consideration for your care, our patients and our staff, we have instituted a Cancellation/Missed Appointment Policy.

Please review the guidelines we have in place to ensure that you get the most out of your experience with our practice.

- Please give 24-hour notice in the event of a cancellation. Giving this notice will allow us to provide that time slot to another patient in need. Patients who cancel in less than 24 hours of their scheduled appointment will be subjected to a $25.00 fee.
- Patients who do not give 24-hour notice AND do not show up to their appointment [“No-Show”] will also be subject to a $25.00 fee.
- Cancellation/No-Show charges are not covered by insurance and will be your responsibility to pay.
- For individuals covered under Workers’ Compensation or No-Fault insurance, we are obligated to inform your physician and case manager of any missed treatment sessions.
- Multiple (more than two) No-Shows for physical therapy appointments will result in discharge from physical therapy due to non-compliance with your treatment plan. This will be documented in your patient record accordingly.

This policy is in place out of respect for our patients and therapists. Thank you in advance for your consideration and cooperation.

BY SIGNING BELOW, YOU ACKNOWLEDGE THAT YOU HAVE READ AND UNDERSTAND THE CANCELLATION POLICY FOR SUSAN BENNETT, PT PC.

PRINT NAME: _____

SIGNATURE: _____ DATE: _____
(Parent or Guardian signature if patient is under 18 years-old)

AUTOMATED APPOINTMENT REMINDERS

By signing below, you have given us permission to send automated text reminders regarding appointments and general clinic announcements. If you would like to opt-out, please leave the below lines empty.

PRINT NAME: _____ SIGNATURE: _____

MOBILE / CELL NUMBER: _____ DATE: _____

BENNETT REHABILITATION INSTITUTE FINANCIAL POLICY
Susan E. Bennett, PT PC

With the start of a new year many insurance plans require the patient to pay a portion of out-of-pocket (called a deductible) before it will pay for services.

High Deductible Plans

Patients with a deductible or coinsurance are asked to pay pre-estimated amounts when checking in. The following are the pre-estimated amounts for each insurance until your deductible has been met.

	IHA	HIGHMARK	UNIVERA
First Visit:	**$95.98**	**$133.58**	**$141.58**
Treatment:	**$43.54 (see below)**	**$48.21**	**$65.00**

IHA

Under IHA high deductible plans the treatment charge(s) are determined depending on the treatment rendered. The cost typically ranges between $43.54 and $65.31. You may be billed the difference from any amount owed above the $43.54.

Medicare

Under Medicare Part B supplementary medical insurance the 2024 deductible is $240.00 and the coinsurance is 20%. When Medicare processes the first claims submitted for 2024 they will use a Pro Rata Data amount for withholding the deductible and the 1st month $161.71 will be withheld and the 2nd month $78.29. Therefore, we will be collecting $81.00 for 2 of our visits in January and then the remainder of $78.00 in February.

You will be billed for any remaining amount due or refunded should you overpay after your bill is processed by your insurance company. If you have any questions regarding this policy please contact our billing office at 716-803-8220.

Printed Name: _____

Signature: _____Date:___/___/____
(Signature of Patient or Guardian if patient is under 18)