Cross Bay Physical Medicine and Rehabilitation, P.C.
Cross Bay Foot Care Center
Cross Bay Physical Therapy

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
E-mail :	SSN #:	Birth date: / /	Age:	Sex: ❑ M ❑ F		
Street address:	Apt.#	Home ph.# ( )	Cell ph#( )			
P.O. box:	City:	State:	ZIP Code:			
Occupation:	Employer:	Employer ph# ( )				
Whom may we thank for referring you?						

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Insurance:					
Subscriber's/Policy Holder name:	Subscriber's SSN #:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

Secondary Insurance :

Subscriber's/Policy Holder name:	Subscriber's SSN #:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name :	Relationship to patient:	Home Phone # ( )	Work Phone# ( )

INSURANCE ASSIGMENT AND RELEASE

I certify that I have insurance coverage with _____ and assign directly to **Dr. Benjamin Bieber / Dr. Debra Weinstock** (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** (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 Medicap insurer and their agents any information needed to determine these benefits for related services.

SIGNATURE OF BENEFICIARY, GUARDIAN OR PERSONAL REPRESENTATIVE

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

entered by_____reviewed by_____Date:_____

Updated: 2/13

Cross Bay Physical Medicine and Rehabilitation, P.C.
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Confidential MEDICAL HISTORY FORM

Name _____ **Birthdate** ___ _____**Date** _____

Chief Complaint:_____

History of Chief Complaint_____

List any allergies you have to drugs, food or other items:

Allergy.....Reaction

_____ _____
_____ _____

List the medications you are now taking:

Medication	Dose	Frequency		Medication	Dose	Frequency	

Do you: Smoke? _____packs per day_____# years smoked_____

When did you quit? _____ Work Status? _____

Primary Care Physician:

Name:_____

Address/Phone:_____

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**

Signature: _____Date:_____

Confidential MEDICAL HISTORY FORM (continued)

Condition	Yes	No	Note
Recent Fever			
Weight loss			
Infection			
Cancer type:			
Skin Condition			
Athlete's foot			
Psoriasis			
Skin cancer			
Hearing loss, Ear condition, Eye condition,Throat problems			
Heart/ Vascular conditions			
Heart attack			
Heart disease			
Congestive heart Failure			
Heart murmur,mitral valve prolapse			
Phlebitis			
Poor circulation			
Bleeding condition			
High blood pressure			
Vascular disease			
Breathing problems			
Asthma, emphysema, bronchitis tuberculosis			
Stomach/ Intestinal			
Liver ulcers			
Diverticlosis, colitis, bowel disease,liver disease, jaundice, hepatitis			
Prostrate problems			
Problems with muscles, joints, or bones			
Arthritis			
Back problems			
Neck problems			
Shoulder problems			
Elbow problems			
Wrist problems			
Hip problems			
Knee problems			
Ankle problems			
Foot problems			
Joint aches			
Weakness			
Malaise			
Rheumatology			
Fibromyalgia			
Gout			
Lupus			
Lyme disease			

SIGNATURE: X_____ DATE:_____

entered by_____reviewed by_____Date:_____ *Updated: 2/13*

Confidential MEDICAL HISTORY FORM (continued)

Polymyalgia rheumatica			
Polymyositis			
Psoriatic arthritis			
Raynaud's syndrome			
Reitor's syndrome			
Rheumatoid arthritis			
Scleroderma			
Sojourn's Disease			
Spinal stenosis			
Endocrine system problems			
Diabetes			
Thyroid problems			
Pancreas problems			
Neurology problems			
Nerve problem-Numbness			
Neuropathy-Radiculopathy			
Stroke			
Unstable Walking			
Falls- Falling			
Walk with cane or walker			
Psychological problems Depression			

List all operations:

Operation Performed	Year	Hospital	Doctor
_____	_____	_____	_____
_____	_____	_____	_____

Please check if any relative (parents, siblings, grandparents, children) have had any of the conditions listed below:

High blood pressure: ____ Kidney Disease:____ Asthma:____ Stroke:____ Cancer:____
Bleeding Tendencies____ Tuberculosis:____Seizures:____ Colitis:____Gout:____
Emphysema: ____ Heart Disease: ____Anemia:____Ulcers:____ Mental Illness:____
Sugar Diabetes: ____ other serious Illness: _____

Vital Signs by History:

Blood Pressure_____Date_____Height_____Date_____Weight_____Date_____

Please list the date and results (if Known) of your last:
X-Ray/ MRI: _____

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

Signature of Patient, Guardian or Personal Representative X_____
Date:_____

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Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____
Patient Name (Please Print) Date

_____
Parent or Authorized Representative (if applicable)

_____
Signature

Insurance Certification

Date: _____

Patient Name: _____
PRINT NAME

All patients are responsible to inform their health care provider if their injuries are either work-related or due to a care accident.

Is this visit due to a work-related injury? Yes No

Is this visit related to a car accident? Yes No

Injury Sites: _____

_____

*** IMPORTANT INFORMATION***

IF YOUR CASE IS WORK RELATED OR AN AUTO ACCIDENT THEN PLEASE NOTIFY OUR OFFICE WHEN YOUR INSURANCE COMPANY SEDNS YOU FOR AN INDEPENDENT MEDICAL EXAMINATION (IME).

FAILURE TO NOTIFY OUR OFFICE OF THIS APPOINTMENT, ANY VISITS ATTENDED AFTER THE IME WILL BECOME PATIENT RESPONSIBILITY!

I certify that the above statements are true.

X_____ _____
Signature of Patient or Responsible party *Date:*

entered by_____reviewed by_____Date:_____ *Updated: 2/13*

Cross Bay Physical Medicine and Rehabilitation, P.C.
Cross Bay Foot Care Center
Cross Bay Physical Therapy

Our Financial Policy

Thank you for choosing us as your health care 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.

All patients must complete our information and insurance form before seeing the doctor. We accept cash, checks, Visa, MasterCard and Discover.

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 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.

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.

Adult patients…

Adult patients are responsible for full payment at time of service.

Minor Patients…

The accompanying adult of minor and /or the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non- emergency treatment will be denied unless payment by cash or check at time of service has been verified.

X_____ Date_____
Signature of patient or responsible party

X_____ Date_____
Signature of co- responsible party

entered by_____reviewed by_____Date:_____ *Updated: 2/13*

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 opiods (narotics, 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 con trolled 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 other wise have access to them.

X_____ Date_____
Signature of patient or responsible party

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS

Motor Vehicle Accident Indemnification Corporation
110 WILLIAM STREET
NEW YORK, N.Y. 10038

DATE	POLICY HOLDER	POLICY NUMBER	**DATE OF ACCIDENT**	CLAIM NUMBER
		N/A		

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE NEW YORK NO-FAULT LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.
2. YOU MUST SIGN ANY ATTACHED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH COPIES OF ANY BILLS YOU HAVE RECEIVED TO DATE.

NAME AND ADDRESS OF APPLICANT *

1. YOUR NAME	2. PHONE NOS. HOME	BUSINESS
3. YOUR ADDRESS (NO., STREET, CITY OR TOWN AND ZIP CODE)	4. DATE OF BIRTH	5. SOCIAL SECURITY NO.
6. DATE AND TIME OF ACCIDENT A.M. P.M.	7. PLACE OF ACCIDENT (STREET), CITY OR TOWN AND STATE	

8. BRIEF DESCRIPTION OF ACCIDENT:

9. DESCRIBE YOUR INJURY:

10. IDENTITY OF VEHICLE YOU OCCUPIED OR OPERATED AT THE TIME OF ACCIDENT:

OWNER'S NAME MAKE YEAR

THIS VEHICLE WAS:

☐ A TRUCK, OR ☐ A BUS OR SCHOOL BUS
☐ A MOTORCYCLE ☐ AN AUTOMOBILE

11. WERE YOU THE DRIVER OF THE MOTOR VEHICLE? ☐ YES ☐ NO
WERE YOU A PASSENGER IN THE MOTOR VEHICLE? ☐ YES ☐ NO
WERE YOU A PEDESTRIAN? ☐ YES ☐ NO
WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD? ☐ YES ☐ NO
DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE? ☐ YES ☐ NO

12. WERE YOU TREATED BY A DOCTOR(S) OR OTHER PERSON(S) FURNISHING HEALTH SERVICES? ☐ YES ☐ NO

NAME AND ADDRESS OF SUCH DOCTOR(S) OR PERSON(S):

13. IF YOU WERE TREATED AT A HOSPITAL(S), WERE YOU AN: OUT-PATIENT ☐ IN-PATIENT ☐

DATE OF ADMISSION: HOSPITAL'S NAME AND ADDRESS:

14. AMOUNT OF HEALTH BILLS TO DATE	15. WILL YOU HAVE MORE HEALTH TREATMENTS(S)	16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT?	
$ _____	☐ YES ☐ NO	☐ YES ☐ NO	
17. DID YOU LOSE TIME FROM WORK? ☐ YES ☐ NO	DATE ABSENCE FROM WORK BEGAN:	HAVE YOU RETURNED TO WORK? ☐ YES ☐ NO	IF YES, DATE RETURNED TO WORK:
AMOUNT OF TIME LOST FROM WORK:	18. WHAT ARE YOUR AVERAGE WEEKLY EARNINGS?	NUMBER OF DAYS YOU WORK PER WEEK:	NUMBER OF HOURS YOU WORK PER DAY:

19. WERE YOU RECEIVING UNEMPLOYMENT BENEFITS AT THE TIME OF THE ACCIDENT? ☐ YES ☐ NO

(Continued on next page)

BRACKETED LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS

20. LIST NAMES AND ADDRESS OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

21. AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? ☐ YES ☐ NO
IF YES, ATTACH EXPLANATION AND AMOUNTS OF SUCH EXPENSES.

22. DUE TO THIS ACCIDENT HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENTS UNDER ANY OF THE FOLLOWING

NEW YORK STATE DISABILITY? ☐ YES ☐ NO

WORKERS' COMPENSATION? ☐ YES ☐ NO

THE APPLICANT AUTHORIZES THE INSURER TO SUBMIT ANY AND ALL OF THESE FORMS TO ANOTHER PARTY OR INSURER IF SUCH IS NECESSARY TO PERFECT ITS RIGHTS OF RECOVERY PROVIDED FOR UNDER THE NO-FAULT LAW.

THIS FORM IS SUBSCRIBED AND AFFIRMED BY THE
APPLICANT AS TRUE UNDER THE PENALTIES OF PERJURY

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

SIGNATURE: _____ DATE: _____

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF WORK AND OTHER LOSS INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES, SALARY OR OTHER LOSS WHILE EMPLOYED BY YOU. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE) _____ SOCIAL SECURITY NO. _____

SIGNATURE _____ DATE _____

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAYS AND PHYSICAL FINDINGS, DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE) _____

SIGNATURE _____ DATE _____

(IF THE APPLICANT IS A MINOR, PARENT OR GUARDIAN SHALL SIGN AND INDICATE CAPACITY AND RELATIONSHIP).

• BRACKETED LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

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NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

Claim Number: _____

I, _____ , ("Assignor") hereby assign to _____ , ("Assignee")
(Print patient's name) (Print hospital or health care provider name)
all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____ , not withstanding any other agreement
(Print accident date)
to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

(Print name of Patient)	**(Signature of Patient)**
	(Date of signature)
(Address of Patient)	
(Print name of Provider)	**(Signature of Provider)**
	(Date of signature)
(Address of Provider)	

NYS FORM NF-AOB (Rev 1/2004)

Cross Bay Physical Medicine and Rehabilitation, P.C.
Cross Bay Foot Care Center
Cross Bay Physical Therapy
Phone: (718) 835-0100
Fax: (718) 843-2233

NoFault Patient Check - List

Patient Name:_____
Date:_____

All No-Fault Patients need to supply our office with:

1. Attorney information including name, address, and phone number.
2. Accident or Police Reports.
3. All information from Insurance Company, including the Claim Representative, and their phone number.
4. A copy of the NF-2 that the insurance company mails to you and requires you to fill out within the first three months of the accident. If your attorney fills this out, it is your responsibility to make sure that either your attorney mails us a copy of the form or you bring it to our office personally.
5. All other Insurance information unrelated to your accident.
6. Please inform us when your work status changes.
7. **Please inform us when you are scheduled for an independent medical exam. (IME)**

If you have any questions regarding above policy, please do not hesitate to ask our No-Fault Case Specialist.

Thank You.

Patient Signature: _____Date:_____

Copy Given to Patient: _____Date:_____