

Registration

Date _____

Last Name		First Name		Middle Init	Sex
Address			City	State	Zip
Home Tel		Bus Tel		Cell	
Date of Birth	Age	SS#	No. of Children	Children's Age(s)	
Email					
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widow(er)		Live <input type="checkbox"/> Alone <input type="checkbox"/> With		No. of stairs to bedroom	No. of stairs outside
Employer Name				Occupation	
Emp. Address				Emp. Tel	
Referred By					
Referring Physician				Telephone	
Other Treating Physicians				Telephone	
Family Physician				Telephone	
Emergency Contact		Relationship		Telephone	
Race: <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> African American <input type="checkbox"/> Other		Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Hebrew <input type="checkbox"/> Russian <input type="checkbox"/> Spanish <input type="checkbox"/> Korean <input type="checkbox"/> Chinese		Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	
Social History: Packs of cigarettes / day		Use of recreational drugs <input type="checkbox"/> Yes <input type="checkbox"/> No		#of alcoholic drinks per week	
Past Medical History <input type="checkbox"/> Diabetes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Increased Cholesterol <input type="checkbox"/> Heartburn <input type="checkbox"/> Heart disease <input type="checkbox"/> Cancer <input type="checkbox"/> Asthma <input type="checkbox"/> Lung Disease <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Ulcer <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Other _____					
Major Surgeries / date		4)			
1)		5)			
2)		6)			
3)		7)			
Current Medications w dosage		4)		8)	
1)		5)		9)	
2)		6)		10)	
3)		7)		11)	
<input type="checkbox"/> Right handed		<input type="checkbox"/> Left handed		Height	Weight
Physical Demands at:		Home		Work	
Sports		Hobbies		Exercises	
Did you have phisycal/occupational therapy elsewhere this calendar year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for what condition? _____ At which facility? _____					
Do you have home nursing, a home aide of home therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Family history: are they any immediate family members with the following: (F – Father, M – Mother, S - Sibling)					
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Heart disease		<input type="checkbox"/> Cancer	
<input type="checkbox"/> Neck problems		<input type="checkbox"/> Joint problems		<input type="checkbox"/> Neurological disorder	
				<input type="checkbox"/> Back problems	
				<input type="checkbox"/> Other family	
<input type="checkbox"/> Please initial this box to allow the doctor to access your prescription history form your pharmacy.					
Pharmacy name:		Address:		Phone:	

ACCIDENT INFORMATION REHAB RN _____ Telephone# _____

MVA Workers' Compensation Date of Accident _____

Name of Insurance Company: _____

Adjuster: _____ Phone #: _____

Claim #: _____

Employer at time of injury: _____

Attorney's Name: _____ Attorney's Phone #: _____

Attorney's Address: _____

Have you filled out & returned your PIP application? Yes No

Has your employer filed an accident report? Yes No

Insured's name if not the same: _____

Address _____
Street City State Zip Code

Telephone _____ Business Telephone _____

Patient's relationship to insured: Self Spouse Child Other _____

Medicare? Yes No If Yes: Number _____ Eff. Date _____ Part A Part B

Insured Individual or Spouse Information: Name _____

Relationship to patient: _____ SS# _____ Date of Birth _____ Telephone _____

Primary Insurance _____

Policy # _____ Group # _____

Address _____ Telephone # _____

Secondary Insurance _____

Policy # _____ Group # _____

Address _____ Telephone # _____

Assignment of Benefits (Medicare/Private Patients):

I authorize payment of medical benefits directly to Howard Liss, MD Rehabilitation Institute, for service described. I accept full responsibility for total amount of bill.

Signature _____ Date _____

I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administrations or their intermediaries or carries, or to the billing agent of this physician, any information needed for this or a related. Medicare Claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Signature _____ Date _____

FOR YOUR INFORMATION: Your appointment is reserved exclusively for you. Please be on time for your appointments. As a courtesy to those patients waiting for appointments, 24 hour notice is required to cancel your appointment. Failure to adhere to this policy may result in a \$50.00 charge.

PRIVATE INSURANCE: If provided with your insurance information and copy of your insurance card, we will process the claim for you and provide all the necessary paperwork to accompany your claim. If your insurance company is slow to pay or denies the claim, it your responsibility to follow up with them. **HOWEVER, YOU ARE RESPONSIBLE FOR YOUR CO-PAYMENT AND ANY DEDUCIBLE AT THE TIME OF SERVICE AND/OR ANY REMAINING BALANCE NOT COVERED BY YOUR INSURANCE.**

MEDICARE: We will submit your claim to Medicare. We accept Medicare assignment; therefore payment will come directly to us. However, you are still responsible for the 20% co-pay of what Medicare approves. If you have a secondary insurer, please be sure to provide us with a copy of your insurance card so we can submit to your secondary carrier.

NO-FAULT INSURANCE: If your claim was verified prior to your appointment, we will submit the bill, to your insurance carrier in lieu of payment at time of service. We expect you to promptly complete and mail to your insurance carrier your PIP from and any other necessary paperwork needed by the carrier to process your claim **YOU WILL BE RESPONSIBLE FOR ANY DEDUCTIBLE AND CO-PAYMENT.** If you have a secondary insurance to cover this balance, it is up to you to file the claim.

WORKER'S COMPENSATION: If you are being seen due to a work related injury, we will file with your compensation carrier – We expect you to provide us with the complete information to properly process your claim – If the insurance carrier denies the claim, you are responsible for the outstanding balance.

SIGNED _____ Date _____

Howard Liss, MD Rehabilitation Institute

HIPPA and Release Form

Date: _____

Name: _____ Date of Birth: _____

Release for Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Spouse _____

Child(ren) _____

Other _____

Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Acknowledgement of Receipt

By signing this page, I acknowledge having received the HIPPA notice that describes how medical information about me may be used and disclosed.

Patient Name: _____

Signature: _____

Date: _____

If you are not the patient:

Relationship the patient: _____

Witness: _____

Signed: _____ Date: _____

Witness: _____ Date: _____

HOWARD LISS, MD REHABILITATION INSTITUTE

NOTICE OF PRIVACY PRACTICES

For more information or to file the written, you may contact our Privacy Officer at the following address:

Howard Liss, MD Rehabilitation Institute
ATTM HIPPA Privacy Officer
177 N. Dean Street #203
Englewood, NJ, 07631
Phone: (201) 390-9200
Fax: (201) 503-0844

For more information about HIPPA or to file a complaint:

Secretary of Health & Human Services
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue S.W.
Washington, D.C., 20201
(202) 619-0257, or Toll Free: 1-877-696-6775

HIPPA NOTICE OF PRIVACY PRACTICES
EFFECTIVE DATE 14.2003

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review carefully.

1. We may use or disclose your health information for purposes of treatment, payment or healthcare operations without obtaining prior authorization. Here is one example for each:

We may provide your health information to health care professionals including doctors, nurses, and technicians-for purposes of providing you with care.

Our billing department may access your information and send relevant parts to insurance companies to allow us to be paid for services we rendered to you.

We may access or send information to our attorneys accountants in the event we need the information in order to address one of our business functions.

2. We may also use or disclose your health information under the following circumstances with our obtaining prior authorization.

To notify and/or communicate with your family: unless you tell us you object, we may use or disclose your health information in order to notify your family or assist in notifying your family, personal representative or another person responsible for your care, about your location, your general condition in the event of your death. If you are unable or unavailable to agree or object, our health professional will use their best judgment in any communications with your family or others.

As required by law:

For public health purposes: we may use or disclose your health information to provide information to state of federal public health authorities, as required by law to prevent or control disease, injury or disability; to report child abuse or neglect; report domestic violence; report to the Food and Drug Administration problems with products and reactions to medications; and report disease or infection exposure. For health oversight activities: we may use or disclose your health information to health agencies during the course of audits, investigations, certifications and other proceedings.

In response to the subpoenas or for judicial and the administrative proceedings: we may use or disclose your health information in the course of any administrative or judicial proceedings. However, in general we will attempt to ensure that you have been made aware of the use or disclosure of your health information.

To law enforcement personnel: we may use or disclose your health information to law enforcement official to identify or locate a suspect, fugitive, material witness, or missing person, comply with a court order or subpoena and other law enforcement purposes.

To coroners or funeral directors: We may use or disclose your health information for purposes of communicating with coroners, medical examiners, and funeral directors.

For purposes of organ donation: We may use or disclose your health information for purposes of communication to organizations involved in procuring, banking or transplanting organs and tissues.