



# The Center for Women's Wellness

713 Troy-Schenectady Road, Suite 215 Latham, N.Y. 12110

Tel: (518) 690-1235 Fax: (518) 690-1245

Welcome to the Center for Women's Wellness, a facility which consists of a team of physical therapists and physical therapist assistants dedicated to the treatment of musculoskeletal issues impacting women throughout the lifespan. Our goal is to provide you with the most effective care to assist you in achieving your maximal level of recovery. Today, you will be seen by a licensed Physical Therapist who will perform an evaluation of your condition. The goals of physical therapy will be discussed with you and will be aimed at returning you to your normal activities. The number of visits a week and the duration of time you should attend therapy will also be discussed. Average visits will last approximately 30 - 45 minutes, however this may vary depending on your condition. You will also be given a home exercise program to be performed as prescribed by your therapist.

Our office will bill your insurance company for physical therapy services. If you have an insurance plan with a co-payment, it is due prior to each office visit. Some insurance plans require that a deductible be met. In this event, we will bill the insurance company, however, you are responsible for rendering payment of services. Some insurance companies have limitations of services approved. **It is your responsibility to contact your insurance company to verify coverage.** In some instances, this may vary from the plan prescribed by your doctor. Again, please refer to your insurance company handout for your benefits.

To accommodate your scheduling needs, our hours of operation are the following:

Monday	9:00 - 8:00
Tuesday	9:00 - 8:00
Wednesday	9:00 - 8:00
Thursday	9:00 - 8:00
Friday	9:00 - 4:00

We require 24 hours notice in the event of a cancellation. There is a \$25.00 charge for a cancellation without proper notice. Thank you for your cooperation.



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## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS/INFORMATION

I, \_\_\_\_\_ authorize The Center for Women's Wellness  
(patient's name)  
to release my medical records and/or medical information to:

\_\_\_\_\_  
(name)

\_\_\_\_\_  
relationship to the patient

For the purpose of:

- Making appointments
- Handling medical information
- Other: \_\_\_\_\_



\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

**\*\*\*PLEASE NOTE:** If someone other than you (the patient) will be handling your billing information, appointment scheduling, changing appointments, etc., you must sign this form in order for us to comply with your request. Thank you for your

# PATIENT INFORMATION FORM

PATIENT NAME:

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_ GENDER: M F

SOCIAL SECURITY NUMBER: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

PERSON TO CONTACT IN AN EMERGENCY: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_ DIAGNOSIS: \_\_\_\_\_

DO YOU HAVE A FOLLOW UP VISIT SCHEDULED WITH YOUR DOCTOR?: YES NO DATE: \_\_\_\_\_

ARE YOU CURRENTLY SEEING A CHIROPRACTOR FOR THIS INJURY?: YES NO

ARE YOU CURRENTLY BEING SEEN AT HOME FOR ANY HEALTHCARE SERVS (ie.: THERAPY, BLOODWORK, OXYGEN, ETC.)? YES NO

HAVE YOU SEEN A PHYSICAL, OCCUPATIONAL, OR SPEECH THERAPIST OR CHIROPRACTOR IN THE PAST YEAR?: YES NO

IS THIS A WORKERS' COMPENSATION CASE? (PLEASE CIRCLE): YES NO

IF YES, EMPLOYER AT THE TIME OF INJURY: \_\_\_\_\_

WORKERS' COMP INSURANCE CARRIER: \_\_\_\_\_

CARRIER ADDRESS: \_\_\_\_\_

CASE MANAGER'S NAME: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

DATE OF INJURY: \_\_\_\_\_ LAST DAY OF WORK: \_\_\_\_\_

CARRIER CASE #: \_\_\_\_\_ WCB#: \_\_\_\_\_

IS THIS A NO FAULT CASE (AUTOMOBILE ACCIDENT): YES NO

IF YES, NAME OF THE NO-FAULT INSURANCE COMPANY: \_\_\_\_\_

INSURANCE COMPANY ADDRESS: \_\_\_\_\_

DATE OF ACCIDENT: \_\_\_\_\_ CLAIM #: \_\_\_\_\_ POLICY #: \_\_\_\_\_

**HEALTH INSURANCE (PRIMARY)**

NAME OF INSURANCE COMPANY: \_\_\_\_\_

ID#: \_\_\_\_\_ GROUP #: \_\_\_\_\_ NAME OF INSURED: \_\_\_\_\_

PATIENT RELATIONSHIP TO INSURED: \_\_\_\_\_ SOC SEC. #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_\_

**SECONDARY HEALTH INSURANCE (IF APPLICABLE)**

NAME OF INSURANCE COMPANY: \_\_\_\_\_

ID#: \_\_\_\_\_ GROUP #: \_\_\_\_\_ NAME OF INSURED: \_\_\_\_\_

PATIENT RELATIONSHIP TO INSURED: \_\_\_\_\_ SOC SEC. #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_\_

"I acknowledge that the information that I have provided to you is accurate to the best of my knowledge. I understand that I am financially responsible for all charges not paid by said insurance, including any co-payments (which I agree to pay prior to services provided), deductibles, coinsurance, as well as any charges for no show and cancellations of appointments. It is further agreed that any patient owed balance not paid within 30 days shall be subject to a 2% monthly charge. In the event of default or if the account is referred to an attorney for collection, the undersigned agrees to pay for any collection or attorney's fees incurred as a result of delinquency."



SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

# PATIENT HEALTH HISTORY

NAME: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

WHEN DID YOUR PROBLEM BEGIN? / / DATE OF VISIT / /

DID YOU HAVE SURGERY? (CIRCLE): YES NO DATE OF SURGERY / /

- PLEASE DESCRIBE THE NATURE AND FREQUENCY OF YOUR PAIN:
- SHARP PAIN
  - DULL PAIN
  - BURNING SENSATION
  - ACHE
  - OCCASIONALLY (25% OR LESS)
  - INTERMITTENT
  - CONSTANT (100%)

PLEASE INDICATE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

INDICATE THE INTENSITY: (NO PAIN) 1 2 3 4 5 6 7 8 9 10 (UNBEARABLE PAIN)

WEIGHT: \_\_\_\_\_ LBS

DOES YOUR PAIN CHANGE WITH MOVEMENT?: YES NO

HEIGHT: \_\_\_\_\_ FT \_\_\_\_\_ IN

IN THE PAST, HAVE YOU BEEN TREATED FOR THE SAME PROBLEM? YES NO

HAS YOUR WORK STATUS CHANGED BECAUSE OF THIS CONDITION? YES NO

SINCE THIS CONDITION BEGAN, YOUR SYMPTOMS HAVE:  DECREASED  NOT CHANGED  INCREASED

IF YOU HAVE EVER HAD A LISTED CONDITION IN THE PAST, PLEASE CHECK IT IN THE PAST COLUMN. IF YOU ARE PRESENTLY TROUBLED BY A PARTICULAR CONDITION, CHECK IT IN THE PRESENT COLUMN. THE INFORMATION YOU PROVIDE CONCERNING PAST AND PRESENT CONDITIONS AND DISEASES ASSISTS YOUR THERAPIST IN MORE THOROUGHLY UNDERSTANDING YOUR STATE OF HEALTH.

	PAST	PRESENT		PAST	PRESENT		PAST	PRESENT
HIGH BLOOD PRESSURE			HEPATITIS			HEART DISEASE		
ANGINA			EPILEPSY/SEIZURES			OPEN HEART SURGERY		
GOUT			DIABETES			PACEMAKER		
STROKE/PARALYSIS			ARTHRITIS			RHEUMATOID ARTHRITIS		
ASTHMA			TUBERCULOSIS			SKIN CONDITIONS		
HIV/AIDS			PREGNANCY			OSTEOPOROSIS/OSTEOPENIA		
CANCER LOCATION:			DRUG OR ALCOHOL DEPENDANCE			FRACTURES		
TUMOR			TOBACCO USER			OTHER:		
SYSTEMIC LUPUS			HEART ATTACK					

MEDICATIONS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

HOSPITALIZATION/SURGICAL PROCEDURES: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

KNOWN ALLERGIES: \_\_\_\_\_

\_\_\_\_\_



PATIENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_



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## FINANCIAL ARRANGEMENTS AND INSURANCE

Dear Patient:

We are committed to providing you with the best possible care. If you have insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of your payment policy.

We participate with:

* Blue Shield of NENY	* No Fault	* MVP
* CDPHP	* Workers Compensation	* GHI / GHI HMO
* Empire BC/BS, Blue Choice, Healthnet	* Medicaid	* Wellcare
* Empire Plan/United Healthcare	* Medicare	* Aetna
	* APA Partners Health	

Through these arrangements, we will bill on behalf of the patient and the patient will be responsible for any co-pays, deductibles or non-approved charges.

### MEDICARE PATIENTS:

We are a participating provider. This means we have agreed to accept assignment on ALL approved charges. Medicare pays us directly 80% of the approved charge. We then will bill the remaining 20% to the secondary insurance company. Patient again is responsible for any co-pays, deductible or non-approved charges.

### COMMERCIAL INSURANCE:

1. We will submit the initial claim directly to your carrier. In the interim, a statement will be sent monthly to the responsible party – THE PATIENT!
2. Your insurance is a contract between you, your employer, and the insurance company. We encourage you to follow up with your carrier to ensure timely payments.
3. Payments for services rendered are due 30 days following the date of service, regardless of insurance.

I understand and agree I am ultimately responsible for the balance on my account.

### WORKERS' COMPENSATION AND NO FAULT:

Patient MUST provide us with an accurate Name and Address of the Insurance Company and the Date of the Accident.

COMP: Employers Name and Carrier Case Number

NO FAULT: Name/Address of Insured, Policy Number and Claim/File Number.

### ADDITIONAL CHARGES:

As a courtesy to other guests and team members, please give us a 24 hour notice of cancellation. Failure to do so will result in a \$25.00 fee.

There will also be a \$25.00 service charge for all returned checks. Our billing office is here to assist you. With your help, we hope to make the payment of this claim a positive experience. Please direct your questions to our billing office at 786-1667. Thank you for your cooperation!

I realize that I am responsible for all collection costs and/or attorney costs incurred by The Center for Women's Wellness in an effort to collect my bill. Balances not paid within 30 days are subject to a finance charge.



SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_



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## PATIENT TREATMENT WAIVER

I, \_\_\_\_\_ am a \_\_\_\_\_ member who is  
(patient name) (insurance company)  
requesting treatment from The Center for Women's Wellness, without the required  
information from my referring physician and/or insurance company. Therefore, I am  
agreeing that I shall be responsible for payment in full for any charges related to any  
office visits for services provided to me or my dependent(s). Furthermore, my above  
named insurance company shall not be responsible for any charges connected with  
this or any unauthorized visit if I do not sign the waiver and/or I fail to obtain the  
required authorization.



Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

This waiver is being used to ensure the integrity and purpose of the primary care  
physician referral system.



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## ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have been advised of the Notice of Privacy Practices from the above named company.

Patient or  
Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

 Witness  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_