



Carmel Medical Care, PC

91 Gleneida Ave; Carmel, NY 10512

P: (845) 228-7000 F: (845) 228-5485

TAX ID # 81-1931257

providers@advancedhealthny.com

Dear Patient:

Welcome to Carmel Medical Care, PC and Advanced Health NY. It is our pleasure to serve your health care needs. This office is a multi-disciplinary medical clinic which employs the talents of medical physicians, physician assistants, physical therapists, chiropractors, massage therapists and physical trainers. During your treatment you will receive care from all members of our team. We work together so our patients receive the most complete and comprehensive treatment available. In order for these treatments to be covered by your insurance, some procedures or modalities may be billed under the physician, the physical therapist and/or the chiropractor, or everything may be billed under one provider. This is dependent on state and federal regulations, insurance company policies and your particular plan.

Our providers are participating in most insurance plans, but not all, so you may have a portion of treatment that will be billed as an out of network provider.

This office uses the American Medical Association's CPT codes for billing all procedures performed in this office. Our fees are either taken directly from the Ingenix custom fee analyzer for this area of the country or are set by your insurance company.

If you have any questions or concerns about any of this, please ask and someone will go over it with you in detail.

I, the undersigned, have read and understand the above information and agree to these terms:

Patient Signature: _____

Date: _____

Patient's Guardian Signature: _____

Date: _____



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Confidential Patient Information

How did you hear about our office: _____

Patient Name: _____ Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____

Age: _____ Date of Birth: _____ Home Phone: _____

Cell Phone: _____ Wok Phone: _____ Marital Status: _____

Occupation: _____ Employer: _____

E-mail: _____ Nearest living relative & Phone # _____

Spouse Name: _____ Spouse work #: _____

Preferred Language: _____ Race: Native American or Alaskan Native Asian
 African American Hispanic or Latino Native Hawaiian or Pacific Islander Not Provided White

Smoking Status: 1-Current every day smoker 2-Current some days smoker 3-Former smoker
 4-Never smoked 5-Smoker status unknown 9-Unknown if ever smoked

Reason For Treatment: Please Answer All Questions. Insurance Companies Require for Authorization For Treatment.

Main Complaint: _____

Additional Complaints: _____

When Did It Start: _____

What Brought It On: Auto Accident Work Injury Yard Work Household Chores Sports Injury
 Lifting Something A Fall Exercising Shoveling Snow Slept Wrong No Specific Reason
 Other Please specify: _____

What Makes It Worse: Work Sleeping Lying Down Sitting Driving Household Chores
 Yard Work Lifting Exercising Walking Taking Care Of Children Increased Activity
 Other Please Specify: _____

What Makes It Better: Sitting Lying Down Sleeping Resting Exercise Shower Heat Ice
 Increased Activity Stretching Nothing Other Please Specify: _____

(PLEASE TURN OVER)



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Current Medications: _____

Other Doctors You Are Seeing For This Problem: _____

Current Treatments: _____

Have You Had A Similar Condition In The Past? _____ How Long Ago? _____

How Was It Treated: _____

Who Is Your Primary Care Physician? Name _____ Phone: _____

Allergies: _____

Please List Any Major Health Problems: _____

Is This Due To An Auto or Work Related Injury? _____ Has A Claim Been Filed? _____

Health Insurance Co.: _____ Policy _____ Primary Insured: _____

Authorization of Payment: I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand and agree that this office will prepare any necessary paperwork to assist me in making collection from the responsible insurance carrier and that any amount authorized to be paid directly to this office, will be credited to my account upon receipt of payment. However, I also understand and agree that all serviced rendered to me are charged directly to me and that I am personally responsible for payment for those services in full. I also understand that if I suspend or discontinue my care for any reason, any fees for services rendered are due and payable immediately. I also agree to assist this office in any way necessary, in collecting any payments due for services rendered to me by this office, from the responsible insurance carrier.

Consent to Treatment: I consent to Medical Care, Physical Therapy, Chiropractic, Massage Therapy, Rehabilitations and related services at this facility. In doing so, I understand, acknowledge and affirm that such services may involve bodily contact, touching and/or direct contact of a sensitive nature. I also understand, acknowledge and affirm that on a rare occasion these services may lead to a temporary increase in pain or soreness and on an even more rare occasion a more serious injury may occur in patients compromised with certain concomitant disease or illness. This includes the 1 in 1 million to 1 in 40 million chance of cerebral vascular accidents during manipulation or mobilization of the neck, the same probability of this occurring while turning your neck or having your hair washed at a salon. This is generally attributed to an underlying defect in the vertebral or basilar artery.

Treatment of Minors: I, as a parent or guardian of a minor receiving treatment, do hereby agree and understand that I have been advised to remain on the premises during any such treatment and waive any claim I may have resulting from failure to do so.

Waiver and Release: I hereby release, discharge, and acquit this facility, it's agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action or loss of any kind arising from my refusal to accept, receive or allow emergency and/or medical services, included but not limited to ambulance service, EMT, physician or urgent care service.

By signing below, I acknowledge and agree to the above:

Patient Signature: _____ Date: _____

Guardian or Responsible Parties Signature: _____

Guardian or Responsible Parties Social Security #: _____

Based on the level of difficulty over the past few days, if you would or could do the following activities, circle the best answer. Please answer all questions, the staff will score your answers. Thank You.

CRC Functional Reporting Index Name: _____ Date: _____

Body Part: Neck · Upper Mid Low Back · Shoulder R L · Knee R L · Other: _____

Self Care:

Scale	0 = No Difficulty	1 = Mild Difficulty	2 = Some Difficulty	3 = Very Difficult	4 = Severe Difficulty	5 = Unable
Getting Dressed, Doing Buttons	0	1	2	3	4	5
Put on, take off shoes and socks	0	1	2	3	4	5
Groom, Wash	0	1	2	3	4	5
Driving	0 (No Limit)	1 (4 hours)	2 (2 hours)	3 (1 hour)	4 (15 min)	5 (Unable)
Cook, prep food	0	1	2	3	4	5
Total: ___/25	0					

Changing and Maintaining Body Position:

Squat	0	1	2	3	4	5
Get in/out: chair, car, bed, bath	0	1	2	3	4	5
Standing	0 (No Limit)	1 (4 hours)	2 (2 hours)	3 (1 hour)	4 (10-30 min)	5 (Unable)
Sitting	0 (No Limit)	1 (4 hours)	2 (2 hours)	3 (1 hour)	4 (10-30 min)	5 (Unable)
Sleeping OR Sleep with Meds	0 (All Night)	1 (6-7 hours)	2 (4-5 hours)	3 (2-3 hours)	4 (1-2 hour)	5 (Unable)
	-----	-----	(All Night)	(4-6 hours)	(2-3 hours)	(1-2 hours)
Total: ___/25	0					

Mobility:

Clean house, perform chores	0	1	2	3	4	5
Travel (cab, bus, train, plane)	0	1	2	3	4	5
Walk	0 (No Limit)	1 (One mile)	2 (1 block)	3 (Btw Rooms)	4 (3-5 Steps)	5 (Unable)
Walk Speed	0 (Run/Sprint)	1 (jog)	2 (Fast Walk)	3 (Normal)	4 (Slowly)	5 (Unable)
Stairs Up/Down	0 (No Limit)	1 (30 steps)	2 (20 Steps)	3 (10 steps)	4 (1-3 steps)	5 (Unable)
Total: ___/25	0					

Handling Objects:

Use tools, appliances	0	1	2	3	4	5
Open doors, jars, bottles	0	1	2	3	4	5
Lift Object from floor	0 (25+ Lbs)	1 (20 Lbs)	2 (15 Lbs)	3 (10 Lbs)	4 (1 - 5 Lbs)	5 (Unable)
Lift Object Overhead	0 (25+ Lbs)	1 (20 Lbs)	2 (15 Lbs)	3 (10 Lbs)	4 (1 - 5 Lbs)	5 (Unable)
Carry bag, box, suitcase	0 (25+ Lbs)	1 (20 Lbs)	2 (15 Lbs)	3 (10 Lbs)	4 (1 - 5 Lbs)	5 (Unable)
Total: ___/25	0					

Totals (add up above totals for total score /100, multiply each category x 4 for category score /100):

Total: ___/100	Self Care = ___/100	Position = ___/100	Mobility = ___/100	Objects = ___/100			
Rating:	CH: 0	CI: 1 to 19	CJ: 20 to 39	CK: 40 to 59	CL: 60 to 79	CM: 80 - 99	CN: 100

LETTER OF NO ACCIDENT OR WORK INJURY

Patient Name: _____

Insurance ID #: _____

Group #: _____

I, _____ hereby state with my signature that I was not involved in any auto accident, slip and fall, or work injury. My treatment is in no way associated with any third party, and no other party is responsible or liable for the cost of my treatment.

Please process and pay all claims immediately.

X _____ Date: _____

**ASSIGNMENT AND INSTRUCTION FOR
DIRECT PAYMENT TO DOCTOR**

I hereby instruct and direct the _____
to pay by check made out and mailed directly to:

Carmel Medical Care, PC
91 Gleneida Ave
Carmel, NY 10512
(845) 228-7000

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make the check out in my name and mailed directly to:

91 Gleneida Ave
Carmel, NY 10512
(845) 228-7000

For the professional expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

With my signature below, the full deductible or co-payment would be a financial hardship on me.

Date: _____

X _____

Policy Holder: _____

X _____

Claimant (if other than policy holder): _____



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STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PHI

Information to be Used or Disclosed:

RELEASE OR OBTAIN ANY AND ALL MEDICAL RECORDS RELATED TO MY MEDICAL CONDITION AND TREATMENT

Purpose of the Disclosure: **COORDINATION OF CARE AND TREATMENT**

May we leave a message on your answering machine? Yes No

Persons Authorized to Use or Disclose This Information:

Carmel Medical Care, Pc; Advanced Health & Injury Care; Advanced Health & Human Performance

Additional Persons to Whom Information May Be Disclosed (include relationship):

Expiration Date of Authorization:

This authorization is effective through ____/____/____ or NO Expiration if blank, unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to our office. You should contact the HIPAA Compliance Officer to terminate this authorization.

Potential for Re-disclosure

Information that is disclosed under this authorization may be re-disclosed by the person or organization to which it is sent. The privacy of this information may not be protected under the Federal Privacy Rule depending on whom the information is disclosed to.

Our practice will not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization. A photocopy of this authorization shall have the same force and effect as an original.

Name of patient

Signature of Patient

Date



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ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES*

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Carmel Medical Care, PC Notice of Privacy Practices*. By signing below, I am “only” giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices*.

Patient Name (Type or Print)

Date

Signature

*A copy of our Privacy Practices is available on our website: www.advancedhealthny.com, posted in our office or upon request.