St. Tereiza
Physical Therapy & Rehab
Better Care. Better Services. Better Results.

1787 Middle Ctry Rd.
Centereach, NY 11720
(631) 467-3381

www.sttereizapt.com/

Dr. Malak Azab, PT, DPT, TPI CGFI, CKTP
Doctor of Physical Therapy

HIPPA Information

We are Physical Therapy Experts and our secrets of pain relief are very effective. Our skilled, caring staff provides excellent care in a healing environment maintaining high standards of professional and personal attention.

We get people better fast! Through manual therapy techniques and cutting-edge functional exercises our physical therapy delivers. Our approach is simple: provide top-notch, individualized care in a fun, friendly, dynamic environment.

We are different because we provide hands-on physical therapy. Our patients receive their manual therapy by a doctor of physical therapy. At St. Tereiza Physical Therapy you see the same doctor of physical therapy every time you walk in the door. Dr. Malak will emphasize functional training to get you back to your every-day activities and athletic endeavors.

We help our patients achieve the highest level of functional independence by improving strength, mobility, balance and coordination. This is accomplished through pain reduction, disability reductions, and function restoration. We care intensely about what we do and what you need. We remove barriers that prevent you from enjoying the basic activities of life.

We are committed to providing convenient high quality, one-on-one physical therapy care in a friendly and caring atmosphere. Our philosophy is to integrate education and exercise in the treatment of the "whole" person. We expect patients to actively participate in their rehabilitation. Our goal is for patients to understand the mechanism of injury, how to facilitate an optimal and speedy recovery, and how to prevent the recurrence of injury. After your evaluation we will send a detailed report stating our findings and our treatment plan to your doctor.

It is important to follow your doctor and PT treatment plan if given a home exercise program. You must attempt to do this as this will shorten your therapy treatment and improve your progress. If your prescription says 3x a week, you should come 3x a week. Again, this will help reach your maximum potential.

Co-pay must be paid at every visit. Again, if your treatment calls for 3x a week you should come 3x a week. If you can not afford the 3rd co-pay or any co-pay please speak to the receptionist/therapist and we will try to make other arrangements. You should never allow a co-payment to compromise your health. Again, if there is a financial reason, talk to someone.

If you have any problems, complaints, or suggestions please do not hesitate to speak with me, Dr. Malak Azab, PT, DPT or one of my receptionists at 631-467-3381.

Thank you,

Dr. Malak Azab, PT, DPT, TPI CGFI, CKTP

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NOTICE OF PATIENT INFORMATION PRACTICES

This notice describes how medical information about you may be used or disclosed and how you can get access to information, please review it carefully. If you have any questions about this policy you may contact our office.

ST. TEREIZA PHYSICAL THERAPY'S LEGAL DUTY

It is the legal duty of St. Tereiza Physical Therapy to protect the confidentiality of your personal health information. We are required to provide you with this notice which outlines our policies and procedures.

USES AND DISCLOSURES OF HEALTH INFORMATION

St. Tereiza Physical Therapy, hereafter referred to as the Practice, uses your personal health information (PHI) in order to provide treatment to you, to be able to obtain payment for your treatment, to perform administrative activities within the practice, and for being able to determine the quality of care that is provided to you. PHI is all the personal information that can identify you: your name, address, telephone number, social security number, health policy number, etc. For example, we may use your PHI to call you about an appointment or to contact your insurance company for payment, speak to your Doctor about your program, or just call you into the treatment area from the waiting room.

The Practice may use your PHI without prior authorization when we are required to do so by law, if there is a public health concern, if you have a communicable disease, if we believe that there is abuse or neglect, for research studies, for legal proceedings, for law enforcement, if a crime occurs in the Practice's office, if an emergency occurs, to funeral directors and coroners, for military activity and national security, and for worker's compensation.

It is policy of St. Tereiza Physical Therapy to get a signed authorization from you prior to releasing your PHI. You have the right to either agree or object to the release information. If you agree and sign a written authorization, you have the right to take back the authorization at a later date if you choose to. If you are not actually present, or unable to agree or disagree to the disclosure of information, the Practice can then use it's professional judgment to decide if the disclosure is in your best interest.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to inspect and ask for a copy of your personal health information at any time. You have the right to ask us to make changes or corrections in your information. The Practice does not have to comply with your request. You have the right to file a disagreement with the Privacy Officer.

You may request a list of all the disclosures that we have made of your PHI for any reason other than for treatment, billing, or administrative activities of the practice.

You also have the right to ask in writing that the Practice not disclose your PHI except when authorized by you, required by law or in the case of an emergency. You may also request that your PHI is not disclosed to family members or friends that may be involved in your care. The Practice will consider all such requests, but it is not required to agree or act on them. You have the right to have confidential information sent to you at an alternative location or by a means other than the postal service.

You have the right to obtain a copy of this notice.

CONCERNS AND COMPLAINTS

If you feel that your privacy rights have been violated at any time or you do not agree with how your PHI is being disclosed, you can contact our Practice. We will not retaliate against you for filing a complaint. You can also contact the Secretary of Health and Human Services.

The terms of this notice may change at any time. A copy of the revised notice will be posted in the office in easily accessible areas and will be provided to you upon your request.

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PATIENT ACKNOWLEDGEMENT OF RECIEPT OF PRIVACY PRACTICES NOTICE

This is to acknowledge that I have received and reviewed St. Tereiza Physical Therapy's Notice of Privacy Practices. If I have any questions, I can contact St. Tereiza Physical Therapy at (631) 467-3381.

PRINT NAME: _____

SIGNATURE: _____ DATE:_____

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PATIENT INFORMATION		**EMAIL ADDRESS**	
First Name:	Last Name:	Mid Init.	Date:
Address:	City:	State:	Zip:
Birth date:	Age:	○ Male ○ Female	S.S.#:
Home Phone:	**Cell Phone:**	***Cell Carrier:**	Spouse:

Chose Clinic because/referred to clinic by: ○ Dr._____ ○ Insurance Plan ○ Family ○ Friend
○ Former Patient ○ Close to work/home ○ Website ○ Yellow Pages ○ Street Sign ○ Brochure ○ Other:

WORK INFORMATION		
Employer:	Work Phone:	Ext.
Occupation:	Employment Status ○ Full Time ○ Part Time ○ Retired ○ Not employed	

CARE PROVIDER INFORMATION	
Referring Dr:	Referring Dr. Phone:
Regular Dr./PCP	Regular Dr./PCP Phone:

INSURANCE INFORMATION	**(PLEASE GIVE YOUR INSURANCE CARE TO RECEPTIONIST)**	
Primary Insurance Name:		
Subscriber's Name (if different)		Birth date:
ID. #:	Group/Policy #	S.S.#:
Patient's Relationship to Subscriber: ○ Self ○ Spouse ○ Child ○ Other:		
Name of Secondary Insurance:		
Subscriber's Name:		Birth date:
ID. #:	Group/Policy #	S.S.#:
Patient's Relationship to Subscriber: ○ Self ○ Spouse ○ Child ○ Other:		

AUTO OR WORK INJURY CLAIM	**(PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)**		
Insurance Name: ○ Auto:	○ Labor & Industries		
Adjuster/Claim Manager:	Phone:		Ext.:
Address:	City:	State:	Zip:
Claim #:	Accident Date:	Cause:	

ATTORNEY INFORMATION			
Name:	Law Firm:	Phone:	
Address:	City:	State:	Zip:

IN CASE OF EMERGENCY		
Name of Local Friend or Relative (not living at same address):		
Relationship to patient:	Home Phone:	Work Phone:

I authorize my insurance benefits be paid directly to St. Tereiza Physical Therapy. I understand that I am financially responsible for any balance. I also authorize St. Tereiza Physical Therapy to release any information required to process my claims.

_____

PATIENT/GUARDIAN SIGNATURE DATE

Initial Questionnaire

St. Tereiza
Physical Therapy & Rehab
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Name:_____

Date:_____

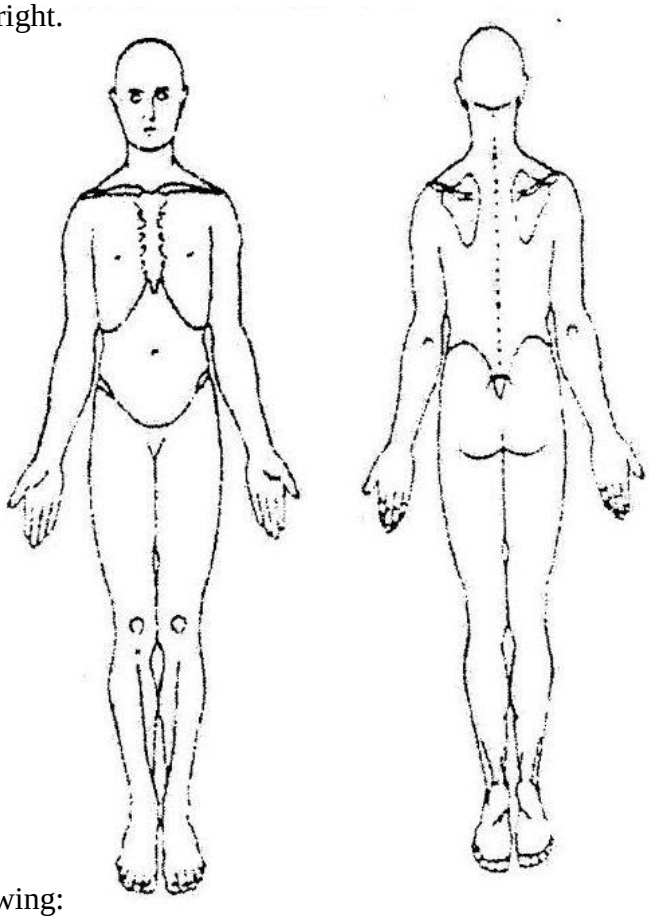
In order to allow the therapist to have a better understanding of the nature of your injury and evaluate your condition fully, please complete the following questions as accurately as possible. Thank you.

1. Briefly describe how your symptoms began or how your injury occurred?_____
_____

2. When did your symptoms start? _____

3. What are your symptoms (i.e./ pain, numbness, tingling)?_____
_____

4. Where are your symptoms? Please mark on the diagram at the right.



5. The onset of my symptoms ☐Gradual ☐ Sudden

6. Date of first doctor's appointment for this injury or for these symptoms was _____

7. My symptoms have
☐ worsened ☐ remained the same ☐ improved

8. My pain over the last few days has been (0-10) _____

9. My symptoms bother me
☐constantly ☐ most of time ☐ occasionally

10. Type of pain?
☐ Sharp ☐ Dull ☐ Throb ☐ Ache ☐ Burning

11. What makes your symptoms worse? _____
_____

12. What makes your symptoms better? _____
_____

13. Since the onset of the injury, have you noticed any of the following:
A. Regular numbness or tingling ☐ Yes ☐ No If yes, where?_____
B. Bowel/bladder control difficulties ☐ Yes ☐ No

14. Have you had imaging of your injury? ☐Yes ☐ No If yes, when did you have your imaging?_____
☐ Xray ☐ MRI ☐ Bone Scan ☐ CT Scan ☐ Ultrasound
What were the results? _____

15. Have you had this pain/problem before? ☐Yes ☐ No
If yes: A) Did you get treatment? ☐Yes ☐ No If yes, did the treatment help? _____
B) What did the treatment consist of?_____

16. What are your goals for physical therapy? _____
_____
_____

17. Is there anything else about you or your condition that you would like us to know? _____
_____
_____

18. Medical History

Please list any surgeries or injuries, for which you have been treated, including fractures, dislocations, sprains.

			DATE
☐ Surgery	☐ Injury	_____	_____
☐ Surgery	☐ Injury	_____	_____
☐ Surgery	☐ Injury	_____	_____

Please review the following conditions. Do you now have/ever have been diagnosed with any of the following?

ASTHMA	Y/N	EMPHYSEMA	Y/N	SENSITVITY TO HEAT/COLD	Y/N
CANCER _____	Y/N	OTHER LUNG PROBLEMS	Y/N	TUBERCULOSIS	Y/N
DIABETES	Y/N	HIV/AIDS	Y/N	OSTEOPOROSIS	Y/N
RHEUMATOID		SEVERE/FREQUENT		SEIZURE DISORDER	Y/N
ARTHRITIS/LUPUS	Y/N	HEADACHES	Y/N		
OSTEO ARTHRITIS	Y/N	THYROID PROBLEMS	Y/N	HERNIA	Y/N
HEART PROBLEMS	Y/N	KIDNEY PROBLEMS	Y/N	STROKE	Y/N
HIGH BLOOD PRESSURE	Y/N	LIVER PROBLEMS	Y/N	ANEMIA	Y/N
HEAD INJURY	Y/N	HEPATITIS _____	Y/N	PACEMAKER	Y/N
ALLERGIES _____	Y/N	MULTIPLE SCLEROSIS	Y/N	INCONTINENCE	Y/N

Have you recently noticed any of the following?

WEIGHT GAIN/LOSS	Y/N	FATIGUE	Y/N	DIZZINESS	Y/N
NAUSEA/VOMITTING	Y/N	WEAKNESS	Y/N	FEVER/CHILLS/SWEATS	Y/N
NIGHT PAIN	Y/N				

Are you pregnant? ☐Yes ☐No If yes, what is your expected due date? _____

MEDICATIONS

Circle any OVER-THE-COUNTER medications you have taken in the last week.

- Aspirin
- Tylenol
- Advil/Motrin/Ibuprofen/Alieve
- Laxatives
- Decongestants
- Antihistamines
- Antacids
- Vitamins/Mineral Substances

Please list any PRESCRIPTION medication you are currently taking (including pills, injections, and/or skin patches) _____
_____
_____
_____
_____
_____
_____
_____

What do you do for recreation? _____
What is your mode of exercise? _____

Patient Signature: _____ Date:_____

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NEWSLETTER OPT-IN AGREEMENT

Thank you for choosing St. Tereiza Physical Therapy. We have created a unique newsletter for you. Each month you will be provided valuable information about services, injury & rehabilitation, and the latest on fitness and personal training.

We will include information about special programs, giveaways, and downloads. Learn about treatments, medical conditions, sports training, fitness, training techniques and more.

Information: **Please Print Clearly!**

Name: _____

E-mail Address: _____

By submitting this information, I confirm that I am only acting for my own e-mail account, or one for which I have express authority to submit this request. Once the subscription is confirmed, I agree to accept newsletter e-mails from St. Tereiza Physical Therapy and my e-mail address will not be used for any other purpose. I understand that I may unsubscribe at any time by following your instructions and that I may still receive a limited number of e-mails while this request is processed.

Signature: _____

ST. TEREIZA PHYSICAL THERAPY WILL NOT SHARE, DISTRIBUTE, OR SELL YOUR E-MAIL ADDRESS.

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TO OUR PATIENTS REGARDING CANCELLATIONS AND NO-SHOWS

The following are our policies regarding cancellations and no-shows. We take this subject seriously at the clinic because it can make the difference between whether you succeed in your treatment or not. Usually your referring doctor and/or your therapist have prescribed a set frequency of treatment. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow your therapist's instructions and we will be able to help you achieve your goals in treatment.

- We require 24 hours notice in the event of a cancellation. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get in the full prescribed number of treatments that week whenever possible.
- There is a $25.00 charge for a cancellation without proper notice. This charge will not be covered by insurance but will have to be paid by you personally.
- For Worker's Compensation and Personal Injury patients documentation of any missed appointments is forwarded to your case manager and primary physician and this could jeopardize your claim.
- Please understand that your pain will probably increase and decrease as your course of treatment progresses and before it is finally erased. Either condition can seem to be a reason not to come in: a) You're feeling worse and think the treatment is not working or, b) you're feeling better and it's a great day for the beach. Neither of these conditions is legitimate as a reason not to come: a) if you're in pain, come in and get it fixed, b) if you're out of pain, now is the time that we can begin doing some real correction of the underlying causes of your problem, educate you so you won't reinjure yourself, etc.

When you don't show as scheduled, three people are hurt: You because you don't get the treatment you need as prescribed by the doctor and/or PT; the therapist who now has a space in their schedule since the time was reserved for you personally; and another patient who could have been scheduled for treatment if you had given proper notice.

Please co-operate with us in this regard. We're looking forward to working with you.

_____ _____

Patient Signature Date

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NO FAULT TERMS AND CONDITIONS FOR PHYSICAL THERAPY

I understand that my No Fault insurance will be billed at the No Fault prevailing rate. However, if my No Fault benefits are denied I understand that I will be responsible for your private fee. I also understand that I cannot be under the care of a chiropractor OR massage therapist while undergoing physical therapy on the same date, or I am responsible for services rendered since No Fault considers this concurrent treatment and will not pay.

Any insurance checks issued and sent to patient for physical therapy services will be signed over to St. Tereiza Physical Therapy. ***If insurance benefits are denied or if there is a deductible on your policy, patients are responsible for payment of services*** (major medical insurance may be used if No Fault denies).

Payment is to be made to this office: St. Tereiza Physical Therapy.

I assign all benefits to Dr. Malak Azab/St. Tereiza Physical Therapy, if any, otherwise payable to me for all services rendered. I understand that I am financially responsible for all charges incurred whether or not paid by my insurance company, including deductibles and co-payments. Interest of 1.5% per month (18% annually) will be charges to overdue accounts. I hereby authorize the release of all information necessary to secure payment benefits. Any collection costs (including attorney fees) will be charged to delinquent accounts, and may be reported to credit rating agencies. I realize that insurance assignment is a courtesy extended by St. Tereiza Physical Therapy PC and that I am ultimately responsible for payment of all services rendered if the insurance company denies payment for any reason to this office.

If I am unable to keep my appointment, I will give the office a 24 hour cancellation notice. If 24 hour notice of cancellation is not given, the regular fee will be charged.

I have read the above, and agree to the terms and conditions.

Signature: _____ Date:_____

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

Date and time of accident: _____ Patient was: Driver____ Passenger____ Pedestrian_____

Policy Holder: _____

Name of No Fault Carrier: _____

Address of No Fault Carrier: _____

Policy #: _____ Claim #: _____

Adjusters Name: _____ Adjuster/Carrier Phone#: _____

Is your No Fault care currently open and active? _____ PIP Deductible (if known) $_____

Are there any benefit limitations? _____ If yes, please describe _____

Attorney's Name: _____ Phone #: _____

Attorney's Address: _____

I _____ ("Assignor") hereby assign to Dr. Malak Azab, PT, DPT, TPI CGFI ("Assignee") 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 to the contrary. (date)

This agreement may be evoked 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 COMMERCAIL OR PERSONAL INSURANCE BENEFITS CONTAINING AND 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.

I hereby authorize the doctor to release information acquired in the course of my examinations or treatments to be released to my no-fault carrier and/or to my attorney.

Patient Name: _____ Patient Signature:_____

Patient Address: _____ Date: _____

Provider Name: Dr. Malak Azab, PT, DPT, TPI CGFI, CKTP 1787 Middle Country Rd, Centereach NY 11720

Provider Signature: _____Date:_____

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE

(This form is not for verification of hospital treatment)

NAME AND ADDRESS OF INSURER OR SELF-INSURER	NAME, ADDRESS & PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

PROVIDER'S NAME AND ADDRESS

St.Tereiza Physical Therapy
1787 Middle Country Road
Centereach, NY 11720

KINDLY COMPLETE AND SUBMIT THIS FORM AS SOON AS POSSIBLE. **PLEASE NOTE COMPLETED FORM MUST BE SUBMITTED TO INSURER NO LATER THAN 180 DAYS AFTER TREATMENT DATE.**

IF YOU HAVE PREVIOUSLY SUBMITTED AN EARLIER REPORT ON THIS ACCIDENT, YOU NEED ONLY NOTE ANY CHANGES FROM THE INFORMATION PREVIOUSLY FURNISHED AND ADDITIONAL CHARGES.

1. PATIENT'S NAME AND ADDRESS

2. AGE	3. SEX	4. OCCUPATION (IF KNOWN)

5. DIAGNOSIS AND CONCURRENT CONDITIONS

6. WHEN DID SYMPTOMS FIRST APPEAR? DATE:	7. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? DATE:

8. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?
☐ YES ☒ NO IF "YES", state when and describe:

9. IS CONDITION SOLELY A RESULT OF THIS AUTOMOBILE ACCIDENT?
☒ YES ☐ NO IF "NO", explain:

10. IS CONDITION DUE TO INJURY ARISING OUT OF PATIENT'S EMPLOYMENT?
☐ YES ☒ NO

11. WILL INJURY RESULT IN SIGNIFICANT DISFIGUREMENT OR PERMANENT DISABILITY?
☐ YES ☐ NO ☒ NOT DETERMINABLE AT THIS TIME
IF "YES", DESCRIBE:

12. PATIENT WAS DISABLED (UNABLE TO WORK) FROM: THROUGH:	13. IF STILL DISABLED THE PATIENT SHOULD BE ABLE TO RETURN TO WORK ON: (DATE)

14. WILL THE PATIENT REQUIRE REHABILITATION AND/OR OCCUPATIONAL THERAPY AS A RESULT OF THE INJURIES SUSTAINED IN THIS ACCIDENT?
☒ YES ☐ No IF "YES", DESCRIBE YOUR RECOMMENDATION BELOW:

NOTE: COMPLETE REVERSE SIDE AND SIGN.

(PAGE 2)

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE

15. REPORT OF SERVICES RENDERED

DATE OF SERVICE	PLACE OF SERVICE INCLUDING ZIP CODE	DESCRIPTION OF TREATMENT OR HEALTH SERVICE RENDERED	FEE SCHEDULE TREATMENT CODE	CHARGES
	St.Tereiza Physical Therapy 1787 Middle Country Road Centereach, NY 11720	Physical Therapy Evaluation & Treatment	97001	$189.00
			TOTAL CHARGES TO DATE $	$189.00

16. IF TREATING PROVIDER IS DIFFERENT THAN BILLING PROVIDER COMPLETE THE FOLLOWING:

TREATING PROVIDER'S NAME	TITLE	LICENSE OR CERTIFICATION NUMBER	BUSINESS RELATIONSHIP CHECK APPLICABLE BOX		
			EMPLOYEE	INDEPENDENT CONTRACTOR	OTHER (SPECIFY)

17. IF THE PROVIDER OF SERVICE IS A PROFESSIONAL SERVICE CORPORATION OR DOING BUSINESS UNDER AN ASSUMED NAME (DBA), LIST THE OWNER AND PROFESSIONAL LICENSING CREDENTIALS OF ALL OWNERS (Provide an additional attachment if necessary).

18. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? ☒ YES ☐ NO

19. ESTIMATED DURATION OF FUTURE TREATMENT

not determinable at this time

(OPTIONAL) 20.
I AUTHORIZE PAYMENT OF HEALTH BENEFITS TO THE UNDERSIGNED HEALTH CARE PROVIDER OR SUPPLIER OF SERVICES DESCRIBED BELOW. I RETAIN ALL RIGHTS, PRIVILEGES AND REMEDIES TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT PROVISION) OF THE INSURANCE LAW.

SIGNED _____
(PATIENT)

OR

(OPTIONAL) 21. ASSIGNMENT OF NO-FAULT BENEFITS:
I HEREBY ASSIGN TO THE HEALTH CARE PROVIDER INDICATED BELOW ALL RIGHTS, PRIVILEGES AND REMEDIES TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT PROVISION) OF THE INSURANCE LAW. THIS AGREEMENT SHALL BECOME NULL AND VOID IF AT ANY TIME IT IS DETERMINED THAT BENEFITS ARE NOT PAYABLE DUE TO THE FOLLOWING CIRCUMSTANCES: LACK OF COVERAGE, VIOLATION OF A POLICY CONDITION, OR DETERMINATION THAT THE TREATMENTS/SERVICES RENDERED ARE NOT RELATED TO SAID MOTOR VEHICLE ACCIDENT. ANY PAYMENT PURSUANT TO THIS ASSIGNMENT SHALL NOT EXCEED THE HEALTH CARE PROVIDER'S PERMISSABLE CHARGES UNDER SAID ARTICLE 51. THE PROVIDER OF HEALTH SERVICES CERTIFIES THAT THEY HAVE NOT RECEIVED ANY PAYMENT FROM OR ON BEHALF OF THE INJURED PARTY AND SHALL NOT PURSUE PAYMENT DIRECTLY FROM THE INJURED PARTY FOR SERVICES PROVIDED DUE TO INJURIES SUSTAINED IN RELATION TO THE AUTOMOBILE ACCIDENT.

SIGNED _____
(PATIENT)

SIGNED _____
(PROVIDER OF HEALTH CARE SERVICE)

"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."

DATE	PROVIDER'S SIGNATURE	IRS/TIN IDENTIFICATION NO.	WCB RATING CODE IF NONE SPECIALTY
		200831048	**PT**

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DELIVERY CONFIRMATION

Name of Patient:_____

In consideration of services rendered or to be rendered, I hereby assign St. Tereiza Physical Therapy the services of my No-fault automobile insurance benefits and rights. Attendant therefore shall equal the bill for such services and the provider or his/her assign in secure same name.

Authorization for the release of Medical Records

Kindly furnish my insurance company or their representatives all information you may have regarding my condition while under your treatment or observation, including the history obtained, x-rays and physical findings, diagnosis and prognosis. You are authorized to provide this information to accordance with the New York State Automobile reparations ac (No Fault Law). In the event the providers charge are outstanding and I fail to file an application for benefits under the New York No-Fault Insurance Law. I hereby authorize the provider to file such claim in my behalf if the provider does not receive in my behalf if the provider does not receive payment from the insurance.

Address:_____

Name of No-Fault Insurance Company:_____

Claim #:_____

Items Received:

1.

2.

3.

4.

5.

Received by:_____ Date:_____

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To Attorney:_____

_____

_____

RE: Reports and Lien for:

_____

Date of Accident: _____

I do hereby authorize the above doctor/medical facility to furnish you, my attorney, with a full report, diagnosis treatment plan, prognosis, etc. for myself in regard to the accident in which I was involved. I hereby authorize and direct you, my attorney, to pay directly to said doctor/medical facility such sums as may I due and owing said doctor/medical facility for medical services rendered to me by reason of this accident and withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect set doctor/medical facility. I further give a lien on my case to said doctor/medical facility against any proceeds of a settlement, judgment or verdict which may be paid to you, my attorney or to me, as the result of the injuries which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor/medical facility for all medical bill submitted by said doctor/medical facility or services rendered to me and that this agreement is made solely if said doctor/medical facility's additional protection and in consideration of said doctor/medical facility awaited payment. I further understand that such payment is not contingent on any settlement, judgment or verdict from which I my eventually recover said fee.

In the case of automobile accidents, where no-fault regulations govern the medical reimbursement, this lien will be effective only to the extent of those applicable no-fault regulations.

Date:_____ Patient's Signature:_____
(Guardian Signature if Patient is a minor)

The undersigned, being the attorney of record for the above patient, does hereby agree to observe the terms of to the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor/medical facility above name.

Date:_____ Attorney Signature:_____