Madge Dargan MA, OTR, CHT • **Janet Krzemienski** MS, OTR, CHT, PLLC

300 East 57th St., NY, NY 10022 PH: (212) 371-2996 FAX: (212) 980-1699 EMAIL: handtherapy57@aol.com WEB: www.handtherapy57.com

Hand Therapy
Orthopaedic Rehabilitation
Orthotic Center

SPECIALISTS IN THE TREATMENT OF TRAUMATIC HAND INJURY, RECONSTRUCTIVE SURGERY, WORK AND SPORTS RELATED INJURY

REFERRED BY DR:_____

NAME: _____ BIRTH DATE: _____AGE:_____ M: __ F: __

ADDRESS: _____ _____APT #: ____ SOCIAL SECURITY #: _____

CITY: _____ _____STATE: ____ ZIP CODE: _____

HOME PHONE: _____ OTHER PHONE: _____ E-MAIL: _____

OCCUPATION: _____ EMPLOYER: _____

PRIMARY INSURANCE : _____ GROUP NAME/POLICY #: _____

SECONDARY INSURANCE: _____ GROUP NAME/POLICY #: _____

DATE OF ACCIDENT: _____ DATE OF SURGERY: _____

HOW INJURY/CONDITION OCCURRED: _____

DIAGNOSIS: _____

ASSIGNMENT OF BENEFITS/ AGREEMENT: I acknowledge and understand that I am responsible for all charges for all services rendered to me or any member of my family. Although I have requested the therapist to bill my insurance carrier, I understand that I am responsible for payment of any unpaid portion of my bill. **I understand and agree to pay for the amount of charges applied to my deductible/coinsurance/co-pay amount contracted by my insurance carrier. I agree to have my deductible, coinsurance or copay charged to my credit card.**

I authorize **Madge Dargan OT Janet Krzemienski OT PLLC,** to submit a claim to my insurance carrier for all services rendered by the Provider, and authorize and direct my insurance carrier to issue payment directly to **Madge Dargan OT Janet Krzemienski OT PLLC.** If payment is not made by the carrier to the provider within **3 months of billing, I agree to make payment in full for all services to the provider.**

I understand that I am responsible for obtaining all necessary referrals required by my insurance carrier. If my insurance contract has a time limit on O.T. (e.g. 60 consecutive days), I understand that I am responsible for any charges rendered passed the allowed period. **I agree to make payment in full directly to the Provider for any dates of service exceeding my contract limit.**

MEDICARE: I request that payment of authorized Medicare and/or Medigap benefits be made to Madge Dargan OT Janet Krzemienski OT PLLC. I understand that I am responsible for the 20% Co-payment not reimbursed by Medicare. I understand that I am responsible for 100% of all the charges incurred beyond the amount allowed by Medicare per year. (see signed waiver of liability agreement)

I authorize any holder of medical information about me to release any information needed to determine these benefits or benefits payable for related services. This authorization is valid for all services until revoked in writing. I certify that all the information provided herein is true and correct.

SIGNATURE: _____ DATE: _____

I hereby authorize and give consent to allow **Madge Dargan OT Janet Krzemienski OT PLLC** to treat a minor.

Signature of Parent or Guardian _____ Relationship to Patient_____Date:_____

Printed Name of Guardian :_____ Phone number: _____

***_____ I was assisted by the office staff to fill out forms and I certify that this accurately represents the information I provided.**

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PATIENT INFORMATION CONSENT FORM

I have read and understand the Practice's Notice of Patient Information Practices. I understand that the Practice may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.

I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the Practice. I also understand that the Practice will consider requests for restrictions on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in the Practice's Notice of Patient Information Practices. I understand that I retain the right to revoke this consent by notifying the Practice, in writing, at any time.

_____ _____

Signature Date

MEDICARE PATIENTS ONLY – Initial only those that apply:

For those who have been issued splints:

____ I certify that I have read and understand the instructions for the wear and care of my splint.

____ I certify that I have received a copy of the DMEPOS Supplier Standards and Protocol for Resolving Complaints and that I have read and understand it.

For those receiving home health care:

____ I understand that if I am receiving home health care provided by Medicare, then today's services will not be covered.

____ Madge Dargan OT Janet Krzemienski OT PLLC Hand Therapy and Orthopaedic Rehabilitation and Splinting Center has advised me that the procedures performed today may not be considered by Medicare to be medically reasonable or necessary and may not be covered. Knowing this, I have instructed Madge Dargan OT Janet Krzemienski OT PLLC proceed with the services. If Medicare decides to reduce / deny the services, I will assume full responsibility for payment and agree to pay Madge Dargan OT Janet Krzemienski OT PLLC Medicare's limiting charge.

_____ _____

Name of Patient (Print) Date

_____ _____

Signature of Patient or Patient Representative Relationship to Patient