Dear Patient:

Welcome to Empire Sports Physical Therapy and Rehabilitation. We are pleased that you have chosen to allow us to help you in your rehabilitation. We hope that we can far exceed your expectations in all aspects of your care.

To best exceed your expectations, we require the completion of the following forms to give us all the information we need to best care for you from your first visit and through full payment either from your insurance company or you. Please fully read these forms, so that your will fully understand our and your responsibilities needed for an exceptional outcome.

The following forms will allow us to be able to assist you in the most complete manner possible.

To allow us to properly submit to your primary and secondary (where applicable) insurances, we ask that you complete all of the enclosed forms, especially the requested insurance information completely and correctly. If you were injured at work, at school, or were otherwise injured, and you do not provide us with the correct insurance information, that is considered insurance fraud. Your insurance company can investigate your claim at any time. The insurance company can deny your claim if you do not list the appropriate insurance or modify or omit any facts surrounding the circumstances of your injury. If your claim is denied for any reason, you then will be responsible to Empire Sports Physical Therapy and Rehabilitation for paying the ENTIRE BALANCE of your bill.

With the information on these forms, we will be able to properly bill your insurance company and be reimbursed appropriately for our service from your insurance provider.

We no longer submit to Tertiary insurance companies, but will give you all the information required after the secondary insurance processes the claim for you to submit on your own behalf

Thank you for your cooperation.

The Professional Team at
Empire Sports Physical Therapy and Rehabilitation

Signature _____

Print Name _____

Date _____

Legal Assignment of Benefits & Designation of Authorized Representative

I, the undersigned, represent that I have valid and in-force insurance and/or employee health care benefits coverage, and hereby assign and convey directly to **Empire Sports Physical Therapy and Rehabilitation and all physical therapy professionals** (the "provider(s)") as my Statutory Derivative Beneficiary (SDB), commonly known as an Designated Authorized Representative, and a Claimant under the "Patient Protection and Affordable Care Act" (PPACA), existing ERISA and other applicable federal and state laws, of all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from the provider(s), regardless of the provider's managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the provider(s) to release all medical information necessary to process my claims under HIPAA.

I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to the Designated Authorized Representative(s) any and all plan documents, including Governing Plan Documents, including, but not limited to a written explanation of how level of benefit payments are determined for out-of-network providers, Summary Plan Description, 5500 Form (Plan Annual Return), Certificate for PPACA Grandfathered Health Plan, where applicable, insurance policy and/or settlement information upon written request from the Designated Authorized Representative(s) in order to claim certain medical benefits in connection for healthcare services provided to the undersigned. This, includes, but is not limited to, receiving disbursement benefit checks for claims submitted, member's rights to appeal claim denials, as well as to claim any applicable statutory penalties on behalf of the plan participant and beneficiary. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the Designated Authorized Representative(s) to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, cause of action, or other right I may have to such group health plans, health insurance issuers or orther insurer(s) under any applicable insurance policies, employee benefits plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I received from the provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but not limited to, (1) obtaining information about the claim to the same extent as the assignor, including, but not limited to, issuance of reimbursement checks, Explanation of Benefits and any/all correspondence related to claims reimbursement; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by the Designated Authorized Representative(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, to bring suit by the Designated Authorized Representative(s) against any such liable party or employee group health plan in my name with derivative standing but at such Designated Authorized Representative(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original.

I have read and fully understand this agreement.

_____	_____	_____
Signature of Insured / Guardian	Print Name of Insured/Guardian	Date

Limited Power of Attorney

I do not believe my employee health benefits plan would prohibit this assignment, but should same be the case or should my assignment be challenged or deemed invalid, I execute this limited/special power of attorney and appoint and authorize your collection attorney as my agent and attorney-in-fact to collect payment for your medical services directly against the carrier in the case, in my name, including filing an arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me and designate your collection attorney as my attorney in fact. I further grant limited power of attorney to you as my medical provider to receive and collect directly from the insurance carrier money due you for services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered to me. I authorize you and or your attorney to receive from my insurer, immediately upon verbal request, all information regarding last payment made by said insurer on my claim, including date of payment and balance of benefits remaining. **Initials_____**

Medical Records Authorization

I authorize you and or your attorney to obtain medical information regarding my physical condition from any other healthcare provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider(s) to release all such information to you about me, including medical reports, x-ray reports, narrative reports and any other report or information regarding my physical condition. **Initials_____**

_____	_____
Patient Signature or Authorized Signature for Minor	**Date**

Financial Policy

The entire staff at our office is dedicated to providing you with the best possible treatment, care and service, and regard your understanding of, and agreement with, our financial policies as an essential element of your care and treatment. If you have any questions, please feel free to discuss them with our staff.

For your convenience, **we accept cash, checks, Visa, MasterCard, Discover and American Express.**

Your Insurance Plan

The fees for our services will be billed to your insurance plan provided the procedure or treatment you are receiving is considered medically necessary. However, you are responsible for the payment of your in-network deductible, co-payments and/or co-insurance no later than at the time of treatment. These fees are mandated by your insurance carrier and cannot be waived. Please be prepared to pay these fees no later than at the time of your treatment. **We accept cash, checks, Visa, MasterCard, Discover and American Express**.

In the event your health plan determines a service /treatment to be "not covered"; you will be responsible for the complete charge or your insurance company does not respond to our invoices. In that event, you will receive a statement and payment in full will be expected within **15 days** of receipt of that statement. We will provide all of the information that you will need to submit for reimbursement from your insurance company.

There are other instances where some insurance plans will send a payment directly to you. If you receive payments for the services you received, you are responsible for forwarding that payment directly to *Empire Sports Physical Therapy and Rehabilitation*. It is your responsibility to ensure the practice is paid the amount that has been sent to you plus any remaining balance. Be advised that not remitting such payment to *Empire Sports Physical Therapy and Rehabilitation* constitutes a breach of contract and an illegal, criminal conversion of funds not belonging to you and *Empire Sports Physical Therapy and Rehabilitation* will pursue all legal and criminal remedies available to it to obtain such payment.

Cancellation/No Show Policy

We, at Empire Sports Physical Therapy and Rehabilitation, feel that being able to complete your physical therapy prescription is an essential part of your treatment, and will make every possible accommodation to assist you to complete your care. Completing your prescribed visits give your physicians the information that they need to make the best decisions regarding your further care possible.

In order to best serve the entire Empire Sports Physical Therapy and Rehabilitation patient community we have implemented a missed appointment/cancellation policy. Please be courteous and call us promptly if you are unable to attend an appointment. We require 24 hours advanced notice of cancellation.

Our cancellation/no show fee is $100 per missed appointment.

If you are able to reschedule the appointment in the same week, you will be made exempt from the cancel/no show fee.

Minor Patients

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.

Return Check Fee

If you make payment to the practice by check and it is returned by the bank for any reason, you will incur a fee of $30.00.

Signature: _____ Date: _____

MEDICAL HISTORY

Patient's name: _____ Date: _____

Past Medical History: (Please choose all that apply to you)

☐ Anemia	☐ Cardiovascular Disease	☐ Hepatitis	☐ Poor Circulation
☐ Arthritis	☐ Cauda Equina Syndrome	☐ High Blood Pressure	☐ Previous Surgery
☐ Asthma	☐ Diabetes	☐ Huntington's	☐ Sickle Cell Anemia
☐ Blood Clotting Disorder	☐ Epilepsy	☐ Immunosuppressive Disease	☐ Stroke
☐ Cancer (When?_____) (Type?_____)	☐ Fibromyalgia	☐ Liver Disease	☐ Traumatic Brain Injury
☐ Cholesterol	☐ Fractures	☐ Lupus	☐ Tuberculosis
☐ Chronic Bronchitis	☐ Gout	☐ Pacemaker	☐ Ulcers
	☐ Heart Disease	☐ Parkinson's Disease	

Other:_____

Please explain any of the above:_____

Social History

Do you currently smoke? Yes/No Amount: _____ Pack (s) a day ____ for _____year(s).

How much alcohol do you drink? ___None ___Occasional ____1-2 Drinks a day ____More

Height_____ **Weight_____**

How did this injury/illness/issue occur/start? _____

_____

When did this injury occur or illness/issue start? _____

If you had a surgery for this issue, what surgery did you have? _____

If you had a surgery for this issue, when was the surgery? _____

Are you currently taking any medications? _____

_____

Allergic to any medication? _____

_____

Other Surgical History. (Date of surgery? Type of surgery? Hospital?) _____

_____

What are your goals for PT? _____

Whom may we thank for referring you? _____

Emergency Contact Information: _____

Name Phone Relationship

_____ _____

Patient Signature or Authorized Signature for Minor **Dat**

Social Media Release Form

As of _____, 20__

For good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, I,_____ (NAME), hereby irrevocably consent to the unrestricted use by Empire Orthopedic Physical Therapy and Rehabilitation, PLLC and its affiliates, subsidiaries, licensees and assigns ("Empire") of any photographs and audio/video footage of me, thank you notes, and/or patient testimonials that GCO obtains through its businesses and activities (collectively, the "Materials"), as well as my name and likeness, and any rights therein, for all promotion of Empire on its owned and operated websites and social media pages (including but not limited to Facebook, Twitter, Instagram, Tumbler, etc.), throughout the world in perpetuity in all languages, formats or media, whether now known or created in the future. You acknowledge that Empire is the sole owner of any rights in the Materials and that you shall not be entitled to injunctive or other equitable relief in connection with Empire's use of the Materials. This Release does not restrict whatever rights Empire may have by law, and Empire is not required to use the Materials.

I warrant that I have the authority to grant this permission and that Empire's exploitation of any of the rights granted herein will not violate any law or any third party's rights.

This Release contains the entire understanding of the parties relating to the subject matter hereof, and supersedes any prior agreements between the parties. This Release will be governed by the laws of the State of New York, and the courts of Rockland County will have exclusive jurisdiction over all disputes that may arise hereunder.

Name: _____

Signature: _____

Address: _____

Telephone: _____

Date of Birth: _____

If the individual is under eighteen (18) years of age, the following must be completed:

I hereby represent that I am the parent or legal guardian* of _____ [NAME] and that I consent to _____ entering into this Release and agree to have _____ be bound by the terms hereof.

Parent or Legal Guardian Signature: _____

Parent or Legal Guardian Name: _____

Date: _____, 20____

*Caretakers, nannies, babysitters, and/or similar persons are NOT legal guardians.