

2140 Bellmore Ave
Bellmore, NY 11710
(516) 586-5533
Fax 516-586-5531



800 East Gate Blvd
Garden City, NY 11530
(516) 745-8050
Fax: 516-745-6766
POOL

Sherrie Glasser MS PT, Owner/Director

Sid Jacobson JCC
300 Forest Drive
East Hills, NY 11548
(516) 626-8787
Fax: 516-626-8789
POOL

333 East Shore Rd
Manhasset, NY
11030
(516) 466-9730
Fax: 516-466-1228

745 Route 25A
Rocky Point, NY 11778
(631) 849-6000
Fax (631) 849-6002
POOL

PHYSICAL THERAPY CONSENT FOR TREATMENT

PROPOSED INTERVENTION/ TREATMENT MAY INCLUDE ONE OR MORE THAN ONE OF THE FOLLOWING:

- Therapeutic Exercise
- Gait Training
- Modalities
- Pool Therapy
- Patient Education
- Bed/ Transfer mobility
- Manuel Therapy
- CPM
- Wound Care

SOME POSSIBLE RISK FACTORS/ COMPLICATIONS INCLUDE:

- Therapeutic exercise: sore muscles and joints
- Transfers and Gait Training: fall, injury from falls.
- Manuel Therapy: sore joints and ligaments. Rarely, dislocation, fracture, paralysis, or death.
- Modalities: rash, burns, skin damage: rare, burning, periosteum.
- Pool Therapy: skin irritations; rare: drowning
- Wound care: skin irritations, infection, spread of infection, increased wound size.

GOAL OF TREATMENT

- Improve mobility
- Improve Function
- Improve Independence
- Decrease Pain

Date: _____

Patient Name: _____

Patient Signature: _____



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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 CAREFULLY.

IF YOU HAVE ANY QUESTIONS ABOUT THIS POLICY, YOU MAY CONTACT OUR OFFICE.

Metropolitan Physical Therapy's Legal Duty: It is the legal duty of Metropolitan Physical Therapy to protect the confidentiality of your personal health information (PHI). We are required to provide you with this notice which outlines policies and procedures.

USES AND DISCLOSURES OF HEALTH INFORMATION

Metropolitan Physical Therapy, hereafter referred to as the Practice, uses your 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 to remind you about an appointment or to contact you insurance information 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 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 Metropolitan 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 of your information. If you agree and sign the written authorization, you have the right to take back the authorization at a later date if you chose 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 PHI 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 after 4/14/2003 for any reason other than 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 requests, but is not required to agree or act on them.

You have the right to have confidential information sent to you at an alternative locations or by 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 privacy officer at the address listed below. The Practice will not retaliate against you for filing complaints. You can also contact the Secretary of Health and Human Services.

**Metropolitan Physical Therapy
800 East Gate Blvd.
Garden City, NY 11530
516-745-8050
Fax: 516-745-6766**

The terms of this notice may change at any time. A copy of the revised notice will be posted in the office in an easily accessible area and will be provided upon your request. This notice was published on May 1, 2003 and becomes effective as of April 14, 2003.



800 East Gate Boulevard Garden City, NY 11530 516-745-8050 Fax: 516-745-6766	333 East Shore Road Manhasset, NY 11030 516-466-9730 Fax: 516-466-1228	2140 Bellmore Ave Bellmore, NY 11710 516-586-5533 Fax 516-586-5531	Roslyn JCC 300 Forest Drive East Hills, NY 11548 516-626-8787 Fax: 516-626-8789
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Patient Acknowledge of Receipt of Privacy Practices Notice

This is to acknowledge that I have received and reviewed Metropolitan Physical Therapy's Notice of Privacy Practices. If I have any questions, I can contact the practice at 516-745-8050.

In addition to the doctors I have provided Metropolitan Physical Therapy with, my medical records may also be released to the following people.

Print name

Signature



Sherrie Glasser, MS, PT
Director

800 East Gate Boulevard
Garden City, NY 11530
(516) 745-8050
Fax (516) 745-6766
(Pool)
Serving Westbury
& Carle Place

Sid Jacobson JCC
300 Forest Drive
East Hills, NY 11548
(516) 626-8787
Fax (516) 626-8789
(Pool)

333 East Shore Road
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Dear Patient,

Since physical therapy is a way of managing symptoms of pain and swelling, the use of electrical stimulation may be incorporated into your treatment.

The electrodes that we use are a self-adhesive electrode that can be re-used and are intended for single patient use for hygienic purposes. Unfortunately, your insurance company does not cover the cost of these electrodes, therefore you will be responsible for the one time charge of \$4.00 - \$10.00 depending on how many electrodes are used for your condition. THIS CHARGE WILL BE EXPECTED AT THE TIME OF SERVICE.

Please be assured that your therapist will properly evaluate and determine the necessary use of electric stimulation to enhance the benefit of physical therapy.

Thank you for your understanding.

Metropolitan Physical Therapy

Signature _____

Date _____

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We are updating our records to make sure that we send progress notes to all of your doctors. We'd appreciate it if you could take a few minutes and give us the names and phone numbers of all of your doctors. Please fill this out and hand it to the receptionist.

Thank you for your time.

Sherrie Glasser, PT, MS

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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. There will be an increased fee if additional equipment or exercise procedure are used, e.g.: Cybex; Nautilus or Eagle. Also, there will be an increase in fee if more than one diagnosis is being treated.

I also understand that I cannot be under the care of a chiropractor while undergoing physical therapy 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 Sherrie Glasser, M.S., P.T. 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: Sherrie Glasser, M.S., P.T.

If this account shall be placed in the hands of an outside attorney for collection, the Responsible Party agrees to pay all costs of collection, including reasonable attorneys' fees not to exceed 20% of the unpaid balance, together with necessary court costs and disbursements.

If I am unable to keep my appointment, I will give the office 24 hour cancellation notice. If 24 hour notice of cancellation is not given, the regular fee will be charged and future appointments will be made on a same day basis.

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

SIGNATURE _____ DATE _____

Patient's Name: _____

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PATIENT'S RESPONSIBILITIES

I understand that I am required by law to see my doctor to get updated prescriptions each month to continue physical therapy. These are needed for insurance purposes and must be handed in at the front desk each month.

I understand failure to comply with the above will either result in the termination of my treatment or if due to automobile accident (No-Fault) denial, will make me responsible for the payment of the visits.

Patient Name

Patient Signature

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ASSIGNMENT OF BENEFITS

I _____ authorize my insurance company to assign the benefits over to Sherrie Glasser, MS,PT. Please make all payments directly to her office. Keep this on file for future bills submitted by her.

Patient Signature

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

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____, ("Assignor") hereby assign to METROPOLITAN PHYSICAL THERAPY, ("Assignee")
(Print patient's name) (Print hospital or health care provider name)
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.
(Print accident date)

This agreement may be revoked 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 COMMERCIAL INSURANCE BENEFITS CONTAINING ANY 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,
COMMITTS 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.

(Print name of Patient)

(Signature of Patient)

(Date of signature)

(Address of Patient)

(Print name of Provider)

(Signature of Provider)

(Date of signature)

(Address of Provider)