ProClinix
SPORTS PHYSICAL THERAPY + CHIROPRACTIC

1 ELM STREET ● ARDSLEY, NY 10502
99 BUSINESS PARK DRIVE ● ARMONK, NY 10504
220 TOMPKINS AVENUE ● PLEASANTVILLE, NY 10570
P: 914.202.0700 F: 914.462.3444 admin@proclinix.com

PHYSICAL THERAPY & CHIROPRACTIC CARE

Patient Information

Name: _____

Social Security #: _____

Date of Birth: _____

Address: _____

_____

Telephone: **Home:** _____

Cell: _____

Email: _____
(Communications are for appointments, office information & newsletters)

Employer: _____

Address: _____

_____

Responsible Party: (if different than above)
*All guardians of minors and those directly responsible for patient finances must complete below.

Name: _____

Address: _____

_____

Telephone: **Home:** _____

Cell: _____

Relationship to Patient: _____

Emergency Contact & Phone#: _____

_____

Is your condition or injury related to an auto accident?
Yes No

Is your condition or injury related to a work related accident?
Yes No

If you answered yes to either question above, please supply the appropriate Auto or Workers Compensation insurance information that will be the primary payer for your services and list your major medical as your secondary coverage.

Do you have a Flex Spending Plan? Yes No

Insurance Information

Primary Insurance Company:

_____

Name of Insured: _____

DOB: (if different from patient)_____

Policy #: _____

Group #: _____

Telephone #: (member benefits # on your card)

_____

Secondary Insurance Company: (if applicable)

_____

Name of Insured:_____

Policy #: _____

Group #: _____

Telephone #: (member benefits # on your card)

_____

***How did you hear about *ProClinix*?** _____

Please read and sign below

I authorize *ProClinix Sports Physical Therapy Chiropractic Wellness, PLLC* to furnish my information to my insurance carrier concerning my condition and treatments if necessary. I am responsible for professional services rendered, regardless of insurance coverage. Payment is expected at time of service, unless other arrangements have been made. I hereby authorize *ProClinix Sports Physical Therapy & Chiropractic PLLC* and whomever they may designate as assistants, to administer Chiropractic and/or Physical Therapy care as deemed necessary. This consent will continue in effect until further notice. By signing below I also acknowledge that I have received the Notice of Privacy Practices and have had an opportunity to review it.

X_____ _____
Patient Signature Date

X_____ _____
Parent/ Guardian's Signature (if patient is a minor) Relationship to patient (if patient is a minor)

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BILLING & CANCELLATION POLICY

Dear Patient:

Thank you for choosing ***ProClinix Sports Physical Therapy Chiropractic Wellness, PLLC***. We are honored that you have selected us to provide you with outstanding professional service. Please note that our services are NOT included in any membership or other contracted services you may have with the facilities in which we are located... **EQUINOX** in Armonk, NY; **HOUSE OF SPORTS** in Ardsley, NY; and **ATHLETES WAREHOUSE** in Pleasantville, NY.

As with any professional office, we have a billing policy in place to ensure minimal confusion and full transparency in the ever changing healthcare and insurance industries. We will always do our best to help our clients receive the reimbursement that their policy allows. Please review the following policy and ask any questions you may have before you accept this policy and sign below.

1. All insurance policies are subject to verification. Once your policy is verified, we will explain your policy allowances for professional services we may have recommended to you.
2. ***ProClinix*** will explain your expected out-of pocket expenses prior to you starting treatment at our facility. The expected out-of-pocket expenses are usually estimates as we cannot be 100% accurate of insurance reimbursement. In some cases, insurance carriers will deny service or not pay at all. In these cases, you will be responsible for denied claims.
3. Your insurance policy is a contract between you and your insurance carrier. ***ProClinix*** reserves the right to accept or not accept policies based on verification of coverage. In most cases we will do our best to accept assignment and submit your bills. On occasion, based on the policy, we may ask for payment for your services and we will give you a bill that you may submit to your carrier.
4. You may be billed for deductibles, co-pays, co-insurances and NON-COVERED services based on your individual policy.
5. If we know a particular service is NON-COVERED, we will have you sign a separate financial form for that particular service.

24-HOUR CANCELLATION POLICY

Please be advised that ***ProClinix*** upholds a 24-hour notice of cancellation as a courtesy to us and our patients. Failure to cancel an appointment within 24 hours of the scheduled appointment will result in a **$40.00** no show fee.

I have read and agree to accept the terms of this billing and cancellation policy for ProClinix Sports Physical Therapy Chiropractic Wellness, PLLC.

_____

PRINTED NAME SIGNATURE DATE

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CREDIT CARD SIGNATURE ON FILE AUTHORIZATION

I, _____ authorize ***ProClinix Sports Physical Therapy Chiropractic Wellness, PLLC*** and its companies to process my credit card information, which will be electronically stored for the sole purpose of office visit charges according to my patient payment responsibility.

Last 4 digits of credit card: XXXXXXXXXXX_____
(to put on file for future card identification purposes only)

Please check type of card on file:

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express
☐ Personal Card ☐ Business Card

_____

PRINTED NAME SIGNATURE DATE

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ASSIGNMENT OF BENEFITS
& INSTRUCTIONS FOR DIRECT PAYMENT TO DOCTOR

I hereby instruct and direct that my insurance company _____ pay by check, made payable to and mailed directly to:

ProClinix Sports Physical Therapy Chiropractic Wellness, PLLC
7 Watch Hill Road
Pleasantville, NY, 10570

OR

If my current policy prohibits direct payment to doctor, then I hereby will endorse any checks I receive from my insurance company _____ and present them to the office.

Endorse checks as follows:

Your Name
Payable to: ProClinix Sports Physical Therapy Chiropractic Wellness, PLLC

For professional or medical 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 THE 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 fees for non-covered services and/or fees over and above the insurance payment or as required by my insurance policy.

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

_____

PRINTED NAME SIGNATURE DATE

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. IT ALSO DESCRIBES HOW YOU MAY ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is very important to us. We understand that your medical information is private and we are committed to protecting it. We do create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements.

USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways in which we use and disclose medical information. We will not use or disclose medical information for any reason not listed below, without your specific authorization. Any specific authorization you initially provide may be revoked at any time by writing to us.

For Treatment

We use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, pharmacies or other professionals caring for your health. We may also share medical information about you to your other health care providers to assist them in treating you.

For Payment

We may use and disclose your medical information for payment purposes (i.e. to insurance companies).

For Notification

We may use or disclose you medical information to notify a family member, your personal representative or another person responsible for your care. We may share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share this information and give you the opportunity to refuse permission. In case of emergency or if you are not able to give permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up prescriptions or to solicit them over the phone or fax machine for you. We may also share any medical information of a person who has died with the coroner, medical examiner or funeral director.

Court Orders and Judicial or Administrative Proceedings

We may discuss medical information in response to a court or administrative order, subpoena, discovery request, or other lawful purpose. We may also disclose medical information to you or your child's school upon request from that institution.

OUR LEGAL DUTY

The Law Requires Us To:

- Keep you medical information private
- Give you this notice describing our legal duty, privacy practices and your rights regarding your medical information
- Abide by the terms of this notice

We Have The Right To:

- Change our privacy practices and he terms of this notice at any time, provided the law permits these changes
- Make this notice effective for all medical information that we keep, included information previously created or received prior to the changes

Notice Of Change To Privacy Practices:

- Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

YOUR INDIVIDAL RIGHTS

You have a right to look at or get copies of your medical information. You must make your request in writing. If requesting copies, we may charge you $0.75 per page and postage if you want the copies mailed to you. You have a right to know with whom we share your medical information. You may request a list at any time. You have the right to place restrictions on our use of disclosure of you medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by the agreement except in case of emergency.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, then please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint. We will not retaliate in any manner if you choose to file a complaint.