OFFICE USE ONLY
THERAPIST:
UPIN#:
CPT:

WELCOME TO OUR OFFICE

TODAY'S DATE ______________________
Diagnosis: ________________
Referring M.D.: ________________________

O'CONNELL, SELIG & ASSOCIATES, L.L.P.
709 West Jericho Turnpike HUNTINGTON, NY 11743
(631) 549-1280

Thank you for choosing our office
In order to serve you properly we will need the following information. (Please print.) All information will be strictly confidential.

Patient's name	M F	Birthdate	Marital Status Single ❑ Married ❑ Widowed ❑ Divorced ❑

Residence address	City	State	Zip	Home phone

If child, parent's name or guardian's name	Cell Phone

Name of employer	Address	Business Phone

Patient's social security number	E-Mail Address	Occupation

Do you have medical insurance? ❑ Yes ❑ No	If no, how do you intend to pay? ❑ Check ❑ Cash ❑ Credit Card	**Primary Ins. Co. name & address**

Subscriber name	Policy no.	Certificate no.	Is this through your employer? ❑ Yes ❑ No

Name of spouse	Insured's Birthdate	Insured's Social Security number

Is there secondary Ins., spouse 2nd carrier, etc.? ❑ Yes ❑ No	Name & address of spouse employer	Business Phone

Secondary ins. name & address	Policy no.	Medicare #

Subscriber name:	Birthdate of insured

Workmen's compensation file #	Date of accident	Name of company

Address of company	Company phone	Adjuster or case manager

Person financially responsible for this account	Address	Relationship to Patient

Nearest friend or relative not residing with you	Relationship to patient	Phone

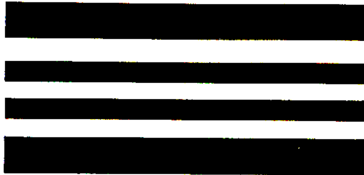
Whom may we thank for referring you?	Address

What is your chief complaint?

I authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for all charges, regardless of insurance coverage.

Patient, Parent, or Guardian Signature____ Date____________________

PLEASE
DO NOT
STAPLE
IN THIS
AREA



PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLACK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTHDATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6 PATIENT'S RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRES (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a.INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

C. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO ***If yes,*** return to and complete item 9a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ______________________ DATE ______________

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ______________________

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17A. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. |________ . __ 3. |________ . __

2. |________ . __ 4. |________ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-92)
FORM OWCP-1500 FORM RRB-1500

O'Connell, Selig & Associates L.L.P.

NOTICE OF PATIENT INFORMATION PRACTICES

O'Connell, Selig & Associates L.L.P.'s LEGAL DUTY

O'Connell, Selig & Associates L.L.P. is required by law to protect the privacy of your child's personal health and educational information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

O'Connell, Selig & Associates L.L.P. uses your child's personal health and educational information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. O'Connell, Selig & Associates L.L.P. may use your child's personal health and educational information to contact you to provide appointment reminders. All authorized personnel are informed of State 7 Federal Confidentiality Laws and sign confidentiality agreements.

O'Connell, Selig & Associates L.L.P. may also use or disclose your child's personal health and educational information without prior authorization for public health purposes when required by law. In other cases, such as external audits you will be notified if the names of the auditors and the purpose of the request. A written consent is required for EIP records. If a consent is given, the individual reviewing the record must comply with all legal requirements that protect all personally identifiable records and records containing sensitive information.

In any other situations, O'Connell, Selig & Associates L.L.P. is mandated by law to obtain your written authorization before disclosing your child's personal health and educational information. If you provide us with a written authorization to release your child's information for any reason, you may later revoke that authorization to stop future disclosures at any time.

O'Connell, Selig & Associates L.L.P. may change its policy at any time. When changes are made, a new Notice of Information Practices will be sent to you. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your child's personal health and educational information at any time. You have the right to request that we correct any inaccurate or incomplete information in their records. You also have the right to request a list of instances where we have disclosed your child's personal health and educational information for reasons other than treatment, payment or other related administrative purposes. In order to access EIP records the parent should contact the Administrative Coordinator of the Early Childhood Services Department. Request to review records may be submitted in writing or verbally. The Administrative Coordinator will document the parent's request on the Record of Early Intervention file access form. Parent may review records on premises or if requesting a mailed copy, a consent form must be signed to release information

CONCERNS AND COMPLAINTS

If you are concerned that O'Connell, Selig & Associates L.L.P. may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your child's personal health and educational information, please contact our practice manager at the address listed below. You may also send a written complaint to the US information practices or if you have a complaint, please contact the following person: Department of Health and Human Services (HIPAA) and/or US Department of Education (FERPA). For further information on O'Connell, Selig & Associates L.L.P's health and educational

Rae Ann Selig, Privacy Officer

O'Connell, Selig & Associates L.L.P.

709 West Jericho Turnpike

Huntington, NY 11743

Telephone: 631-549-1280 Fax: 631-549-1005

I have read, fully understand, and accept O'Connell, Selig & Associates L.L.P.'s notice of information practices.

____________________________________ ____________________

Child's name Date of Birth

____________________________________ ____________________

Parent/Guardian's Signature Date

O'Connell, Selig & Associates, L.L.P.

Pediatric & Adult Therapies

709 West Jericho Tpk., Huntington, NY 11743
Phone (631) 549-1280 Fax (631) 549-1005

Date: ______________________________

Re: ______________________________
(Name of patient)

I understand that if ___________________________ denies me payment for physical
(Name of insurance company)
therapy treatments, I agree to pay O'Connell and Selig for any and all of my unpaid treatments at our regular rates until such time that my insurance company gives me authorization for payment.

Our regular rates:

Initial Evaluation - $200.00
½ hour treatment - $70.00

____
(Signature of patient)

O'Connell, Selig & Associates, L.L.P.

Pediatric & Adult Therapies

709 West Jericho Tpk., Huntington, NY 11743
Phone (631) 549-1280 Fax (631) 549-1005

MEDICAL RECORDS RELEASE CONSENT FORM

On this day of __________________________________, I authorize O'Connell, Selig & Associates to release all Physical Therapy medical records to: _______________________

____

____

____________________________	____________________________
O'Connell, Selig & Associates, LLP	Parent or Guardian's Signature