NORTH JERSEY PHYSICAL THERAPY GROUP

An affiliate of North Jersey Orthopedic Group

First Name _____ MI _____

Last Name _____

Address _____

_____

City _____ State _____ Zip _____

Home Phone _____

Work Phone _____

Cell Phone _____

Email Address: _____

Parent/Guardian (if minor) _____

S.S. Number _____

Today's Date _____

Date of Birth _____

Age _____

Sex: M F Marital Status: S M D W

Date of Injury/Onset _____

Injury Area _____

Accident Related: Yes No

If Accident: Auto Work Other

Primary Insurance _____

Group # _____

ID # _____

Secondary Insurance _____

Group # _____

ID # _____

Insured Name _____

Relationship to Patient _____

Insured's Date of Birth _____ Insured Sex: M F

Insured Name _____

Relationship to Patient _____

Insured's Date of Birth _____ Insured Sex: M F

INSURANCE BENEFITS

In the past few years the number of different health insurance programs has increased at an amazing rate. Even within one company there may be several programs with varying benefits and requirements. There is no way that we can possibly know or keep up to date with each program's provisions.

- Some programs require a specific facility to be used to be eligible for benefits. Some programs require pre-authorization while others do not. Some programs require a signed referral form, which is different than a prescription, from your primary care physician for any consultations or treatments with a specialist physician. Some programs require a copayment for each visit and/or a coinsurance. There are some programs that only allow a certain number of procedures done in one day.

IT MUST BE YOUR RESPONSIBILITY TO KNOW AND ADVISE US OF YOUR PROGRAMS'S REQUIREMENTS IN ADVANCE, EACH AND EVERYTIME WE PROVIDE A SERVICE. We will do our best to comply with any requirements that your program may have. Please understand that if we provide a service that is outside of your program, you will be responsible for these appropriate fees.

THESE ARE NOT OUR REGULATIONS; THEY ARE YOUR INSURANCE COMPANY'S REGULATIONS. Unless you follow them carefully, the insurance company may decline all or part of your claim. Your insurance carrier should have provided you with a phone number to be used if you have any questions about your coverage.

OUR CANCELLATION POLICY

Canceled/No Show Policy: If a patient fails to show for an appointment there will be a charge of $50.00. If a patient cancels an appointment with less than 24 hours notice three times the patient may be discharged from physical therapy at the therapist's discretion. Our physical therapist reserve time out of their schedule for your appointment. We ask that if you are not able to keep the appointment, please extend us the courtesy of a phone call to cancel, so we may schedule another patient in that time slot.

I hereby assign the policy rights and benefits to the Therapist, and authorized direct payment for professional services rendered. I further authorize the attending Therapist to release any information concerning my examination or treatment to my physicians and/or Insurance company. I AGREE TO BE PERSONALLY RESPONSIBLE FOR ANY UNPAID BALANCE OR CO-PAYMENT.

I acknowledge receipt of this information

PATIENT'S SIGNATURE (or Parent) : _____ **DATE:** _____

MEDICAL HISTORY / SUBJECTIVE INFORMATION

Name:_____ Date:___/___/___ Age:_____

Height:_____ Weight:_____ Primary Care Physician:_____

Medical History: **(Please Answer "Y" (Yes) or "N" (No) to Each of the Following)**

___Heart Disease	___Diabetes	___High Blood Pressure	___Pacemaker
___Cancer	___Tuberculosis	___Visually Impaired	___Epilepsy/Seizures
___Arthritis	___Asthma	___Hearing Impaired	___Fibromyalgia
___Stroke	___Scoliosis	___Latex Allergy	___Osteoporosis
___GI Disorders	___Pregnant: ___Current ___Past		

Other Medical Conditions: _____

_____

The following questions pertain to the condition you are here for today.

Have you had surgery for your condition? **Y** **N** If yes, approximate date:_____

Have you had any injections for your condition? **Y** **N** If yes, approximate date:_____

Please list any diagnostic tests you have had for your condition: _____

Please list all medications that you are taking:_____

What are your symptoms?_____

When did the injury or symptoms occur?

First episode:_____ *Second episode*:_____ *Third episode*:_____

Please rate your pain using a 0 – 10 scale (0 = no pain, 10 = the worst pain you can imagine):

Worst pain since onset:_____ *Least* pain since onset:_____ *Today's* pain:_____

Where is your pain located?_____

Is your pain: **Constant**? **Intermittent**?

What makes your pain/problem **better**?_____ **Worse**?_____

Is there pain present at night? **Y** **N** What position helps you to sleep?_____

Employment History:

Are you currently working? **Y** **N** If no, how many days of work have you missed?_____

Are your duties: **Full** **Restricted** How many hours per week do you work?_____

What type of work do you do?_____

What critical work duties have been most affected by your problem?_____

What do you hope to accomplish with therapy?_____

Please complete the following page→

PLEASE RATE YOUR ABILITIES USING THE FOLLOWING SCALE:

1 = CAN DO WITHOUT DIFFICULTY
2 = CAN DO WITH SOME DIFFICULTY
3 = CAN DO WITH GREAT DIFFICULTY
4 = CAN'T DO AT ALL

					COMMENTS:
Lying down	1	2	3	4	
Sitting	1	2	3	4	_____
Standing	1	2	3	4	
Walking	1	2	3	4	_____
Jogging/running	1	2	3	4	
Going up stairs	1	2	3	4	_____
Going down stairs	1	2	3	4	
Lifting/carrying	1	2	3	4	_____
Driving a car	1	2	3	4	
Overhead reaching	1	2	3	4	_____
Housework	1	2	3	4	
Yardwork	1	2	3	4	_____
Dressing	1	2	3	4	

Are you exercising at home? **Y** **N** If yes, what type?_____

Are you using heat or cold? **Y** **N** If yes, what type?_____

Do you smoke? **Y** **N** If yes, how much?_____

What type of non-work activities are you involved in?_____

When are you scheduled to see the doctor again?_____

How did you hear about North Jersey Physical Therapy Group? (Circle One)

Primary MD Orthopedic MD Personal / Family Referral Hospital Insurance Company

Newspaper Other _____

To the best of my knowledge the information I have given is complete and true.

Patient Signature:_____ Date:____/____/____

Patient Name: _____ Date: _____

North Jersey Physical Therapy Group

Assignment of Benefits

I irrevocably assign to North Jersey Physical Therapy Group all of my rights and benefits under any insurance contracts for payment for services rendered to me by North Jersey Physical Therapy Group. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claim by North Jersey Physical Therapy Group to be released to North Jersey Physical Therapy Group. I irrevocably authorize North Jersey Physical Therapy Group to act on my behalf and report any suspected violations of proper claims practices to the proper regulatory authorities.

I irrevocably authorize North Jersey Physical Therapy Group to obtain counsel and enter legal or other actions on my behalf and or in my name, including the arbitration/dispute resolution process, and to collect such sums due it, should sums not be paid within the legally prescribed time frame. In the event that North Jersey Physical Therapy Group elects to bring a lawsuit or petition for arbitration/dispute resolution against the insurance carrier, I am irrevocably assigning my rights, title and interest under medical expense benefits and/or PIP section of any insurance policy which I am entitled to proceed for benefits. This assignment shall allow an attorney of North Jersey Physical Therapy Group's choosing to bring suit or submit to arbitration/dispute resolution their claim for any unpaid bills for services rendered for injuries that I sustained in this or any accident.

In the event that this assignment is held invalid for any reason, I hereby authorize North Jersey Physical Therapy Group to appoint an attorney of its choice to represent me directly against an insurer for which I may collect PIP benefits and to bring a claim in a forum of its choice. This appointment is intended in enabling the attorney to collect the bills of North Jersey Physical Therapy Group.

The undersigned patient does hereby agree and acknowledge that he or she may receive benefit checks directly from the insurance carrier for services rendered by the provider. The undersigned patient hereby agrees to immediately forward said checks to North Jersey Physical Therapy Group upon receipt of the same.

A photocopy of this assignment shall be valid as the original. The assignment of benefits has been explained to my full satisfaction and I understand its nature and effect.

_____ _____

Patient Date

_____ _____

Parent or Guardian (if patient is a minor) Date

EFFECTIVE IMMEDIATELY *NORTH JERSEY PHYSICAL THERAPY* (*an Affiliate of North Jersey Orthopedic Group*) **HAS IMPLEMENTED A POLICY FOR ALL "NO SHOW" APPOINTMENTS**

IF AN APPOINTMENT IS NOT CANCELLED WITHIN 24 HOURS OF YOUR APPOINTMENT THERE WILL BE A CHARGE OF $50.00.

When you do not show up for a scheduled appointment, it creates an unused appointment slot that could have been used for another patient. It is imperative that you call 24 hours in advance to cancel your appointment.

PLEASE SIGN BELOW INDICATING YOU HAVE BEEN ADVISED OF THIS POLICY.
If you have any questions regarding this policy please feel free to speak to the staff.

PATIENT NAME PATIENT SIGNATURE DATE

NORTH JERSEY PHYSICAL THERAPY GROUP