

# NORTH JERSEY PHYSICAL THERAPY GROUP

*An affiliate of North Jersey Orthopedic Group*

First Name \_\_\_\_\_ MI \_\_\_\_\_ S.S. Number \_\_\_\_\_  
Last Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
Address \_\_\_\_\_ Date of Birth \_\_\_\_\_  
\_\_\_\_\_ Age \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Sex: M F Marital Status: S M D W  
Home Phone \_\_\_\_\_ Date of Injury/Onset \_\_\_\_\_  
Work Phone \_\_\_\_\_ Injury Area \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Accident Related: Yes No  
Email Address: \_\_\_\_\_  
Parent/Guardian (if minor) \_\_\_\_\_ If Accident: Auto Work Other

Primary Insurance \_\_\_\_\_ Insured Name \_\_\_\_\_  
Group # \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
ID # \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_ Insured Sex: M F  
Secondary Insurance \_\_\_\_\_ Insured Name \_\_\_\_\_  
Group # \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
ID # \_\_\_\_\_ 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:** \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**North Jersey Physical Therapy Group**

*Physical Therapy Registration*

Describe your symptoms: \_\_\_\_\_

When did your symptoms start? \_\_\_\_\_

How did your symptoms begin? \_\_\_\_\_

Did you have surgery?  No  Yes If so, when and what \_\_\_\_\_

Please list medications you are currently taking:

\_\_\_\_\_

\_\_\_\_\_

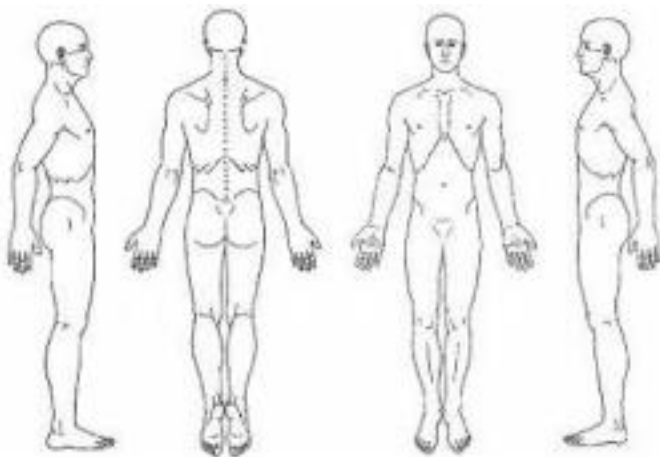
I am not taking any med(s) at this time

Please check any areas in which you have previously had, or currently have, medical problems:  Allergies

Diabetes  Fractures  High BP  Pacemaker  Currently Pregnant  Low BP  Cancer  Headaches

HIV/AIDS  Dizziness  Visual/Hearing Difficulties  Circulation Problems  Heart Conditions  Surgery(ies):

On the diagram below, indicate where you have pain or other symptoms:



What describes the nature of your symptoms?

- Sharp  Burning
- Shooting  Numb
- Dull Ache  Tingling

How are your symptoms changing?

- Getting Better
- Not Changing
- Getting Worse

How often do you experience your symptoms?

- Constantly (76-100% of the day)
- Frequently (51-75% of the day)
- Occasionally (26-50% of the day)

Intermittently (0-25% of the day)

During the past 4 weeks, indicate the average intensity of your symptoms:

0 None)  1  2  3  4  5  6  7  8  9  10 (Unbearable)

During the past 4 weeks, how much has pain interfered with normal work, including housework and work outside the home:  Not at all  A little bit  Moderately  Quite a bit  Extremely

Who have you seen for your symptoms?

No one  Chiropractor  Medical Doctor  Physical Therapist  Other: \_\_\_\_\_

Have you had similar symptoms in the past? If you have received treatment in the past for the same or similar symptoms, who did you see?

No  Yes:  This office  Chiropractor  Medical Doctor  Physical Therapist  Other: \_\_\_\_\_

What is your occupation: \_\_\_\_\_

What do you do for recreation: \_\_\_\_\_

Who is your referring doctor? \_\_\_\_\_

# No Show and Late Policy

## **Late Policy**

- If you are more than 15 minutes late and have not contacted NJPTG, we hold the right to consider your appointment a NO SHOW. We reserve the right to charge you a \$50 fee.

## **NO SHOW Policy**

- If you have a scheduled appointment and do not come to your appointment, or arrive more than 15 minutes late to a scheduled appointment, we reserve the right to charge you \$50 no-show Fee.

**Late and No show Fees are not billable to any form of insurance**  
We truly don't want to have to charge YOU FOR SESSIONS YOU DID NOT ATTEND. These policies are in place because we've found that they encourage patient compliance to their rehabilitation goals. Thank you for understanding and participation.

Patient name

Patient Signature

Date

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**NORTH JERSEY PHYSICAL THERAPY GROUP**  
*An Affiliate of North Jersey Orthopedic Group*

**Assignment of Benefits**

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

I irrevocably authorize NJPTG 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 NJPTG 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 NJPTG'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 NJPTG 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 form of its choice. This appointment is intended in enabling the attorney to collect the bills of NJPTG.

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

# **NORTH JERSEY PHYSICAL THERAPY GROUP**

*An affiliation of North Jersey Orthopaedic Group*

Fred Knight, PT, DPT, Cara SanTERS, PT, Christian Delacruz, PT, DPT

## **DISCLOSURE OF INSURANCE PARTICIPATION STATUS AND FEES**

The laws of the State of New Jersey and New Jersey Department of Health require that health care professional inform patients of the health care plans in which the professional participates in *and* the facilities with which the professional is affiliated with. In compliance with these laws, the undersigned patient is hereby notified, in writing, that:

### **Health Plans Health Care Professional Participates With:**

- 1) New Jersey Medicare Part B

### **Facilities Physician Is Associated with and Address:**

**North Jersey Physical Therapy, LLC**

If the patient's, health plan is not listed above, the physician and/or facilities providing services does not participate with the patient's health plan. In order to proceed with any health care services, the patient hereby acknowledges and agrees:

### **Licensed Assistant Healthcare Staff:**

The following licensed healthcare professionals may perform assistant services on the patient based upon the treatment plan and needs of the patient:

- 1) Fred Knight, PT, DPT
- 2) Cara SanTERS, PT
- 3) Christian Delacruz, PT, DPT

**Locations: 246 Hamburg Turnpike, Suite 303 Wayne NJ 07470 Phone: 973-720-1110**

### **Mandatory Disclosures:**

- 1) I understand that the healthcare professional that I am seeking healthcare services from is "out-of-network" and does not participate with my health insurance plan;

Patient initials: \_\_\_\_\_

- 2) I understand that the amount or estimated amount the health care professional will bill the covered person for the services is available upon request;

Patient initials: \_\_\_\_\_

- 3) I may request from the provider an estimated charge for the services proposed and the Current Procedural terminology (CPT) codes associated with that service, and the health care professional shall disclose to me, the patient, in writing, the amount or estimated amount that the health care professional will bill the covered person for the services the CPT codes associated with that service, absent unforeseen medical circumstances that may arise when the health care service is provided;

Patient initials: \_\_\_\_\_

- 4) I understand that I will have a financial responsibility applicable to health care services provided by an out-of-network professional, in excess of my in-network copayment, deductible, coinsurance, and that I may be responsible for any costs in excess of those allowed by their health benefits plan;

Patient initials: \_\_\_\_\_

- 5) I have been advised that I should contact my health insurance plan or administrator for further consultation on those costs.

Patient initials: \_\_\_\_\_

The healthcare provider and patient both acknowledge and agree that receipt or acknowledgement by patient of these disclosures shall not waive or otherwise affect any protection under existing statutes or regulations regarding in-network health benefits plan coverage available to the patient under the law.

The health care provider acknowledges and agrees that, if, between the time these disclosures are made to the patient and the time the health care service takes place, the network status of any of the health care professional changes as it relates to the patient's health benefits plan, the professional shall notify the patient promptly.

### **Acknowledgement of Receipt of Disclosures**

I, the undersigned patient acknowledges receipt of this disclosure form from my health care provider, and have read it and understand the contents. I have discussed my option to obtain treatment with other health care providers, service providers, or at alternative health care facilities at may participate with my health plan and I waive the right to do so and wish to obtain my treatment at this office with full notice of these disclosures and potential cost sharing consequences. I certify that I am at least 18 years of age, competent, not under the influence of any drug, alcohol or other substance that would impair my ability to understand these disclosures, am not being coerced to sign this disclosure, and do so upon my own free will.

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_.