WELCOME TO OUR CLINIC

On behalf of the entire staff, we would like to welcome you to our clinic. We are pleased to have the opportunity to assist you with your physical therapy care. Our goal is to provide the highest quality and most up-to-date physical therapy treatments available in a professional and caring manner. We are committed to helping you attain your rehabilitation goals. It is also our goal to provide you with outstanding service.

We would like to review a few of the office policies with you. We believe this will improve your understanding of how our office works, and will enable you to receive the maximum benefit from the physical therapy treatments you will receive.

Our office policies are as follows:

- Your appointment time begins at the time noted on the appointment list. Our goal is to keep your waiting time, to a minimum.
- Should you arrive past your appointment time, we will do everything we can to ensure you receive the maximum benefit from your program. Please understand our commitment to outstanding service extends to all of our clients.
- If you need to cancel an appointment, please understand that this can set you back in your rehab process. If you still need to cancel, make sure you do it with **no less than 24hrs notice.** We ask this to assist your Physical Therapist with getting others in who may be waiting for an appointment. If you do not call before a scheduled appointment, you will be charged a $25 No Call/No Show fee, *which is NOT covered by insurance*.
- We will call and verify your insurance to obtain pertinent information regarding your benefits. **However, it is your responsibility to be aware of any visit limitations or other stipulations your insurance may have regarding physical therapy. We are not responsible for inaccurate or mistaken information from the insurance company regarding your benefits.**
- We will provide your doctor with a report of your progress at the time of your follow up visit with him/her. Please notify us of your follow up appointment and any appointment changes that may occur so that we can prepare your report accordingly.

Thank you for choosing Jersey Physical Therapy. Should you have any questions or comments, please do not hesitate to contact us directly.

Signature: ____ Today's Date______________________

Patient or Parent/Guardian (If Under 18)

PATIENT INFORMATION

jersey PHYSICAL THERAPY

Name____ ☐ Male ☐ Female
First MI Last

Address____
Street Address Apt # City State Zip Code

Phone #'s: (______) ______-__________ (______) ______-__________ (______) ______-__________
Area Code Home Phone Area Code Work Phone Area Code Cell Phone

Date of Birth ______/______/______ Age: ______________ Social Security #______-______-______
Month Day Year

Employer: ______________________ Occupation: ______________________

IF WORKERS COMPENSATION case, Employer's Name & address:______________________

____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other **Onset of Current Injury**____/_____/______

Emergency Contact: ______________________ Phone (______) ______-__________
Area Code

E-mail Address: ______________________

Physician Information

Referring Physician: ______________________ Office Phone (_____) ______-__________
First Last Area Code

Primary Care Physician: ______________________ Office Phone (_____) ______-__________
First Last Area Code

Primary Insurance Information

Name of Policy Holder ______________________ ____/_____/______ ______-______-______
First Last Date of Birth Social Security Number

Address of Policy Holder ______________________
(If Different from Above) Street Address City State Zip Code

Relationship to Patient ______________________

Secondary Insurance

Name of Policy Holder ______________________ ____/_____/______ ______-______-______
First Last Date of Birth Social Security Number

Address of Policy Holder ______________________
(If Different from Above) Street Address City State Zip Code

Relationship to Patient ______________________

NOTICE OF PRIVACY POLICIES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. You have the right to review our Notice and ask questions about our privacy practices. The terms of our notice may chance. Upon request, a copy of our revised notice will be made available to you. I **have read and understand the Notice of Privacy Practices.**

COMMUNICATION

I authorize Jersey Physical Therapy to leave detailed messages regarding my Medical information and any Billing/Account balance issues on the secure Phone number and E-mail address I've provided below:

Phone Number: ______________________ E-mail address: ______________________

Patient Name: ______________________

Signature: ______________________ Today's Date: ______________________

(Parent or Legal Guardian if patient is under 18)

Jersey Physical Therapy

MEDICAL HISTORY

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Claustrophobia	☐	☐	Seizures	☐	☐
Cardiac Condition	☐	☐	Kidney Problems	☐	☐	Dizzy Spells	☐	☐
Heart Attack	☐	☐	Liver Problems	☐	☐	Diabetes	☐	☐
Pacemaker	☐	☐	Cancer	☐	☐	Allergies	☐	☐
Circulation Problems	☐	☐	Vision Problems	☐	☐	Fractures	☐	☐
Arthritis	☐	☐	Speech Problems	☐	☐	Strokes	☐	☐
Osteoporosis	☐	☐	Sensitivity to Heat	☐	☐	Mental Illness	☐	☐
Nervous Disorders	☐	☐	Sensitivity to Cold	☐	☐	Smoker	☐	☐
Asthma	☐	☐	Metal Implants	☐	☐	Alcoholism or Drug use	☐	☐
						Are you pregnant?	☐	☐

Height: ______________________ Weight: ___________________

Have you suffered from any illnesses not listed above? ☐ Yes ☐ No If yes, please explain:

____

Have you ever had surgery including this current condition? ☐ Yes ☐ No
If yes, please list the type of surgery and the year it was done:

Type:______________________ Date: ___________ Type: __________________________ Date: __________
Type: _____________________ Date: ___________ Type: __________________________ Date: __________

Have you had therapy for your current condition? ☐ Yes ☐ No If yes, please list:
Location: _______________________________ Dates: _______________________ Number of Visits: _____________

Please list all medications, or herbal supplements you are taking: (*Please specify the Route of Administration-ROA*)
*Please use the back of this page for additional medications.

Type: ____________________ Dosage: ____________________ Frequency______________ ROA: ________________

Type: ____________________ Dosage: ____________________ Frequency ______________ ROA: ________________

Type: ____________________ Dosage: ____________________ Frequency ______________ ROA: ________________

What body part are we treating? __________________________________Date of Injury_____/______/________

Are we treating you as a result of a fall? ☐ Yes ☐ No
Have you fallen more then twice in the last year? ☐ Yes ☐ No
Describe the history of your present condition. Please provide all important details:

____

____

Authorization for Treatment

I, the undersigned, do hereby agree and give my consent for Jersey Physical Therapy Associates, LLC, to furnish all medical care and treatment considered necessary and proper in diagnosing and treating my current condition.

Print Patient's Name: ____

Signature: ____ Date ___________________________

Patient or Parent/Guardian (If Under 18)

jersey PHYSICAL THERAPY

RESPONSIBILITY STATEMENT

Jersey Physical Therapy Associates, LLC, has agreed to wait for your insurance company to pay our charges in lieu of immediate payment by yourself. This courtesy in no way releases you, the patient, from the ultimate responsibility for Jersey Physical Therapy Associates' charges. Your insurance coverage is not a substitute for payment; it is merely one method you may use to pay our charges. Most insurance companies have limits to the amounts they will pay for our services. These limitations are written into the contract that you, the patient, sign with them. Jersey Physical Therapy Associates, LLC, has no control over the amounts your particular insurance company may or may not pay. Any portion of our charges that is not paid by your insurance company immediately becomes your responsibility, unless prohibited by laws governing motor vehicle PIP coverage and/or Worker's Compensation insurance coverage.

Jersey Physical Therapy Associates, LLC, has called your insurance company to determine a preliminary quotation for coverage for outpatient physical therapy services. This information is in no way a guarantee of payment. Your insurance company will make a final determination of eligibility upon receipt of the claim.

Jersey Physical Therapy Associates, LLC, considers an explanation of benefits, (E.O.B.) received with or without payment from your insurance company to be the final word on what you may owe for each submitted claim. If a claim is paid incorrectly, Jersey Physical Therapy Associate, LLC, still requires payment from you as stated in the E.O.B., but will assist you in learning ways to resubmit the claim and have the correct amount refunded to you.

Jersey Physical Therapy Associates, LLC, has business contracts with several insurance companies that require us to accept a reduced fee schedule in exchange for the right to be able to treat each company's insured individuals. If we are so required by your insurance company, the E.O.B. will clearly state what portion of our charges are considered over and above the contracted fee schedule. If this applies to your policy, you would not be responsible for any amounts specifically labeled discounted, but you are still liable for any and all other charges as per the above policies and procedures. This includes, but is not limited to, your failure, if applicable, to maintain a physician's prescription that is current within the past 30 days.

As the responsible party for payment of Jersey Physical Therapy Associates' charges for providing physical therapy services, I state that I have read and completely accept my rights and responsibilities with regards to the above policies and procedures.

Signed: ____ Date: ___________________________

Patient: ____

WELCOME TO OUR CLINIC

ASSIGNMENT OF BENEFITS

I hereby assign all medical benefits, to include major medical benefits, to which I am entitled to, including Medicare and other government sponsored programs, private insurances, and other health plans to Jersey Physical Therapy, LLC, who accepts this assignment.

I understand and agree that insurance claim forms will be submitted to my insurance company as a matter of convenience only and that I am financially responsible for ALL CHARGES regardless of my existing medical coverage and whether or not they are paid by said insurance. **In the event that my insurance company forwards payment directly to me, instead of Jersey Physical Therapy, I will immediately deliver such payment to Jersey Physical Therapy Associates. I understand that these checks are payment to Jersey Physical Therapy for services rendered. X _______**

Initial

I understand and agree that if it becomes necessary to commence legal action for the collection of any outstanding charges on my account, I will be responsible for any costs and or court fees, in addition to the outstanding balance.

JPT will bill patients on a monthly basis for the balance of charges not covered by their insurance company. We request payment of any balance due within sixty days of the date of the bill. After sixty days, balances due will be billed at a rate including an additional 1.5% interest fee per month. We accept payments in the form of cash, check, VISA and Mastercard.

I understand and agree that after 90 days if I have not paid my account in full, Jersey Physical Therapy will forward my account to an outside collection agency for processing. I agree to reimburse JPT the fees of any collection agency, which may be based on a percentage at a maximum of 40% of the debt, and all costs, and expenses, including reasonable attorneys' fees incurred in such collection efforts, in addition to the outstanding balance.

RELEASE OF INFORMATION

I hereby authorize Jersey Physical Therapy Associates, LLC to disclose or obtain any and all parts of my or my dependents records to or from any person or corporation which may be liable for all or part charges of Jersey Physical Therapy Associates, LLC. This includes but is not limited to, insurance companies, worker's compensation carriers or employers to secure said benefits.

I have read and understand the insurance/financial policy.

Signature: ____ Date ______________________

Patient or Parent/Guardian (If Under 18)