72 Main Street Little Falls NJ 07424

T: (973) 857-1616 F: (973) 500-6806

PATIENT REGISTRATION

Name: _____ Soc. Sec #: _____-_____-_____

Gender: _____ Age: _____ Date of Birth: _____/_____/_____ Marital Status: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Home: (_____) _____-_____ Cell: (_____) _____-_____ Work: (_____) _____-_____

E-mail Address: _____@_____._____

Would you like appointment reminders? ☐Yes! send me E-mail Reminders ☐ No reminders

EMERGENCY CONTACT

Name: _____ Relationship: _____

Phone Number: (_____) _____-_____ E-mail: _____@_____._____

May we share your private information with this person? ☐Yes ☐No

INSURANCE INFORMATION

Primary Insurance: _____ Are you the Primary Insurance Policy Holder? ☐Yes ☐No

If NO, please fill out below:

Primary Policy Holder Name: _____ Relationship to primary insured: _____

Date of Birth: _____/_____/_____

Secondary Insurance (if applicable): _____ Are you the Primary Insurance Policy Holder? ☐Yes ☐No

If NO, please fill out below:

Primary Policy Holder Name: _____ Relationship to primary insured: _____

Date of Birth: _____/_____/_____

WORKER'S COMPENSATION & AUTOMOBILE ACCIDENT CASES

Case Manager: _____ Tel: (_____) _____-_____ Ext.: _____

Case Number: _____ Date of Occurrence: _____/_____/_____

EMPLOYMENT INFORMATION

Circle one: Full Time Part Time Unemployed Retired

Employer: _____ Telephone #: (_____) _____-_____

Address: _____ Occupation: _____

►Patient Signature: _____ **► Date:** _____/_____/_____

Medical History

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Patient Name_____ Date_____ Height _____ Weight _____lbs

Allergies_____

Current Medications_____

_____

Check those conditions that apply to you:

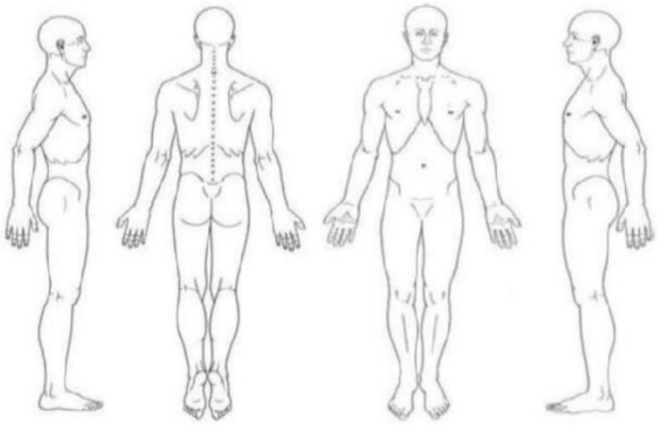
Heart Disease
Respiratory Disease
Diabetes *Taking insulin? Yes / No*
Seizure Disorder *Date of last seizure* _____
CVA (Cerebrovascular accident or stroke) *Date*_____
High Blood Pressure
Current Pregnancy *Due Date*_____
Dizziness / Fainting / Nausea (please circle)
Recent Surgeries *Type/Date*_____

Depression
Alcohol Abuse History
Drug Abuse History
Smoker *How much?*_____ *How many years?*____
Cancer *What Type?*_____
Infectious Disease *Explain*_____
Other _____

Please describe your current symptoms:

How often do you experience your symptoms?
Indicate where you have pain or other 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)



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

During the past 4 weeks

• Please indicate on the line where your pain is in relation to the 2 extremes

No pain ***Worst Pain***

□0 □1 □2 □3 □4 □5 □6 □7 □8 □9 □10

How much has pain interfered with your normal work activities?

Not At All **A little bit** **Moderately** **Quite a bit** **Extremely**

Patient Signature_____ Date _____

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INSURANCE AUTHORIZATION, FINANCIAL POLICY, AND AGREEMENT

We are committed to providing you with the best possible care. If you have insurance, we will gladly accept assignment of benefits and file all insurance claims, provided verification of your insurance policy(s) allows assigned benefits and coverage for the services rendered.

Please read the following statements carefully. By signing below you agree that you have read and fully understand all statements contained herein.

I hereby authorize payment directly from my insurance carrier to the rehabilitation agency for the benefits due to me in my pending claim. I further authorize release of any medical information required by my insurance carrier.

►Patient Signature: _____ **► Date:** _____/_____/_____

I, the undersigned, understand that the rehabilitation agency will bill my insurance carrier for the services rendered upon verification of coverage from my insurance company. I also understand that should my insurance company fail to make complete payment for services rendered, I am responsible for complete payment of physical therapy services, including any and all deductibles, coinsurance amounts. I am responsible for payments that are denied for lack of medical necessity as determined by your health insurance payer. The charges incurred are not subject to any fee schedule or reductions unless the rehabilitation agency is a contracted managed care provider for my insurance carrier. I also understand that if my treatment is due to an injury which results in litigation against a third party, this in no way relieves me of my obligation to pay for the services rendered. I understand that payments of the fees are not contingent upon a settlement of litigation; however, I hereby instruct my attorney to pay the rehab agency in full, directly from the proceeds from any settlement or judgment rendered on my behalf.

EXPLANATION OF MEDICARE BENEFITS

Accepting the assignment means that the provider of services agrees to accept the “allowable” charges as determined by Medicare as full payment. However, you must remember Medicare generally pays 80% of the allowable charges. Therefore, you are still responsible for the 20% balance. In addition to the 20% you are responsible for any amounts applied toward your annual Part B deductible and any non-covered charges.

SUPPLEMENTAL COVERAGE/CO-PAYMENT

A rehab agency representative has explained to me that under Medicare guidelines, I will be responsible for 20% of the allowable charge. The rehab agency has agreed to accept assignment of benefits on this portion of the charges; I also understand that should the supplemental insurance company fail to pay for these charges within a “reasonable length of time”, or send payment directly to me, I will become responsible for payment in full.

WORKMAN’S COMPENSATION COVERAGE

The rehab agency agrees to treat and bill worker’s compensation for the preauthorized work related injuries, per the Worker’s Compensation Guidelines. However, if for any reason Worker’s Compensation denies liability for the treatment of the injury, I understand I become responsible for full payment of the charges.

DIRECT ACCESS COVERAGE

The rehab agency agrees to treat and bill patient's insurance for 10 visits within 30 days of initial treatment should the patient request treatment without a referral from a doctor per the New Jersey State guidelines. Services without a referral might not be covered by the patient’s health plan or insurer; said services might be covered by health plan or insurer with a referral.

The above Patient Financial Policy and Agreement has been read and/or explained to me:

►Patient Signature: _____ **► Date:** _____/_____/_____

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HIPAA PRIVATE PRACTICE FORM

I have received, read, and understand the Total Recovery Physical Therapy
HIPAA Private Practice form.

► **Patient Signature:** _____ ► **Date:** _____/_____/_____

CANCELLATION POLICY

In the event that I am unable to attend my scheduled session and fail to notify Total Recovery Physical Therapy at least **24 hours** in advance of that session,
I will be obligated to pay a cancellation fee of $75.00.

► **Patient Signature:** _____ ► **Date:** _____/_____/_____