TRPT
TOTAL RECOVERY
PHYSICAL THERAPY

72 Main Street
Little Falls, NJ 07424
T: 973-857-1616 | F: 973-500-6806

PATIENT REGISTRATION

Name: _____ Gender: _____ Age: _____

Date of Birth: _____/_____/_____ Marital Status: _____ Address:

_____ Apt: _____

City:_____ State: _____ Zip: _____

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

E-mail Address: _____@_____._____

Would you like appointment reminders? Email Reminders Text Message No reminders

Who can we thank for referring you? How did you hear about us? _____

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: _____

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Medical History

Patient Name_____ Date_____ Height _____ Weight _____lbs

Allergies_____

Please Indicate all current medications_____

_____

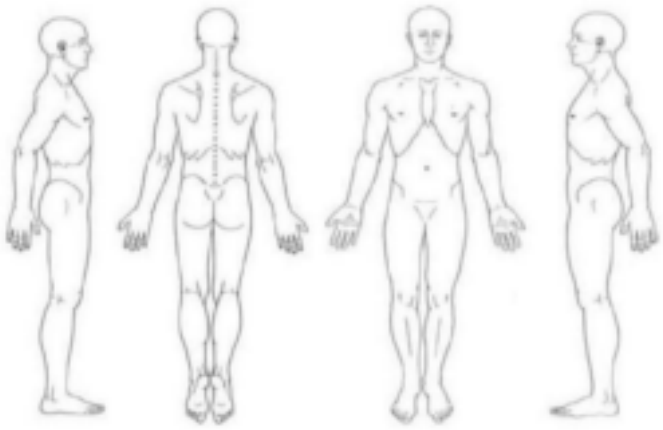
Please describe your current symptoms: _____

How and when did they start? _____

How often do you experience your symptoms? _____

Have you gone to the ER for this condition? N/Y **If Yes By Ambulance?** N/Y

Indicate where you have pain or other symptoms on the figures below:



Frequency of 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
Shooting
Dull Ache
Burning
Numb
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

How much has pain interfered with your normal work activities? (Please circle)
Not At All A little bit Moderately Quite a bit Extremely

Have you been treated for this condition before? N/Y **If Yes what kind of treatment and by whom?** _____
_____

Do you Exercise? N/Y **What type?** _____ **How Often?** _____

Do you have a family history of any of the following? (Please circle)
Cancer Thyroid Condition Diabetes High Blood Pressure Low Blood Pressure Heart Disease Arthritis Depression

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Please indicate if any of the following apply to you:

Headache
Neck Pain
Neck Stiffness
Jaw Pain
Shoulder Pain
Hand Pain
Hip Pain
Leg Pain
Foot Pain
Numbness in fingers Numbness in toes
Pins/needles in arms Pins/needles in legs
Joint swelling
Stiffness in joints Fainting
Loss of consciousness Dizziness
Seizures
Nausea

Balance problems
Chest pains
Shortness of breath Loss of appetite
Unexplainable weight loss
Night sweats
Pain worse at night Sleep problems
Excessive thirst
Frequent urination
Constipation
Diarrhea
Colitis/IBS
Heartburn
Ulcer
Asthma
Respiratory problems

Chronic cough/bronchitis
Difficulty swallowing
Loss of bladder control
Loss of bowel control
High blood pressure
Low blood pressure
Kidney stones
Arthritis
Diabetes
Cancer kind:_____
Stroke date:_____
Heart Attack date:_____ Bypass
Pacemaker
Metal implants
Other surgery: _____

Please list any hospitalizations:_____

How often do you use Tobacco: (Please circle) Daily Weekly Monthly Yearly Never

How often do you use Alcohol: (Please circle) Daily Weekly Monthly Yearly Never

Have you had, or do you currently have any of the following issues? (If so please describe)

Gastrointestinal_____
Cardiovascular_____
Kidney/Renal_____
Thyroid_____
Eye Problems_____
Hearing difficulties_____
Diabetes_____
Prostate or gynecological health_____
Occupation:_____
Children? N/Y Number and age(s) _____

Are you currently pregnant? _____
Are you on birth control? N/Y Kind_____
Date of last menses: _____

Have you been to a chiropractor before? N/Y If yes anything we should know? _____
Have you been to physical therapy this year? N/Y If yes How many visits? _____

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

► **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.

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 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 a 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:** _____/_____/_____

MEDICALLY INFORMED CONSENT

I have been informed of the nature of my disorder(s) and of the nature and purpose of physical therapy and related therapeutic procedures for treatment. I voluntarily consent to physical therapy treatment and services deemed necessary by my physical therapist and/or physician. I acknowledge that no guarantees have been made to me as to the results of services at Total Recovery PT. I have read this form and fully understand and accept its terms and conditions.

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

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CANCELLATION & NO SHOW POLICY

TRPT requires 24 hours notice to cancel or reschedule your appointment.

We understand life happens and you may need to miss a scheduled appointment. However, please be considerate and provide adequate notice if you cannot make it. When you cancel late, we are unable to give that appointment to someone else who needs our assistance.

Please note, we charge a missed visit fee of $50 for no-shows and cancellations with *less than 24 hours notice*.

This amount is your responsibility as insurance will not cover a missed visit fee.

To avoid the fee, call the office to reschedule any appointments within the same week, Monday-Saturday, when you cannot attend 24 hours in advance.

I have read the above and will comply with this policy.

_____

Signature Date

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Informed Consent for Chiropractic Treatment

I have been informed of the nature of my disorder(s) and of the nature and purpose of chiropractic procedures and related therapeutics proposed as treatment. I have also been informed of the possible consequences and risks inherent in such treatment. The availability of alternative treatment options has been explained to me. I have also been advised of the possible consequences if I decided not to receive care. I understand that there is no guarantee or warranty for any specific result.

I have read the above paragraph and I understand the information provided. This information has been explained to me and all questions which I have asked have been answered to my satisfaction.

I therefore authorize the office of Dr. Lawrence Peters to proceed with chiropractic care and treatment.

Patient's Name (print) _____ Patient's Signature _____

Date _____

When the patient is a minor or unable to consent to treatment:

Select one:

_____ The patient is a minor of _____ years of age

_____ Other reason: _____

Patient's Name (print) _____

Name of person **legally authorized** to sign for the patient:

Name (print) _____

Signature _____ Date _____

Relationship:_____

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PHOTO CONSENT AND RELEASE FORM

Patient Name: _____

I consent for photographs and/or video images to be taken of me by Total Recovery P.T., PC or a representative. I understand the images will be a part of my medical record and may be used for purposes of medical teaching or training or for marketing purposes (website, print, digital or social media).

By consenting to photographs and/or video images I understand I will not be compensated from any party. Although photographs and/or video images will be used without identifying information such as name, I understand it is possible someone may recognize me.

I further acknowledge that my participation is voluntary and agree that use of any photographs and/or video images confers no rights of ownership or royalties whatsoever.

I authorize the use of photographs and/or video images: (please initial indicating YES or NO below)

_____ YES _____ NO For educational purposes (medical teaching or training),

_____ YES _____ NO For marketing and advertising purposes (website, print, digital, or social media),

_____ YES _____ NO At my request, my photographs and/or video images will only be used as part of my medical record.

I hereby release Total Recovery P.T., PC, its employees, and any third parties involved in the creation of or publication of educational or marketing materials, from liability for any claims by me or any third party in connection with my participation.

By signing this form, I confirm understanding of this consent. If I wish to withdraw my consent in the future, I may do so via written request submitted to Total Recovery P.T., PC or by completion of a new form.

Patient Signature: _____ Date: _____