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? ☐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: ______________________

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

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# Medical History

Patient Name________________________________________ Date______________________ Height __________ Weight ________lbs

Allergies_________________________________________________________________________________________________________

Please Indicate all current medications______________________________________________________________________________

_________________________________________________________________________________________________________________

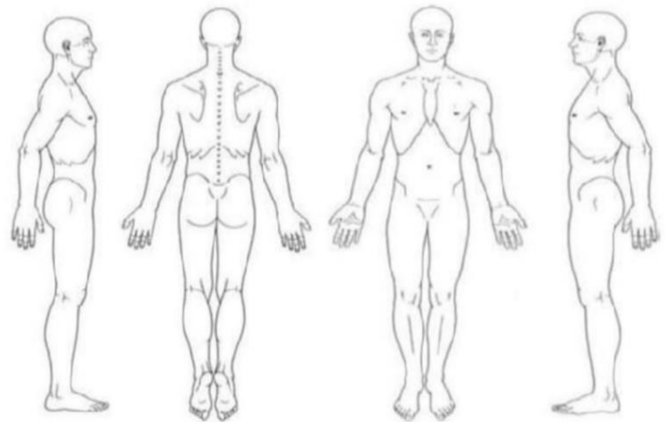
**Please describe your current symptoms:** _______________________________________________________________

**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:**

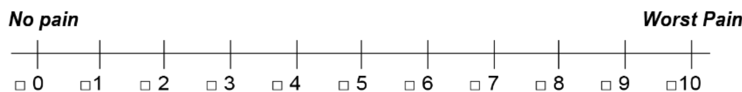


**Frequency of symptoms:**
Constantly (76-100% of the day)
Frequently (51-75% of the day)
Occasionally (26-50 % of the day)
Intermittently ( 0-25% of the day)

**What describes the nature of your symptoms?**
Sharp
Shooting
Dul 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?** ___________________________

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**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

**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
Inexplainable 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? ______________________________

►**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 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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## 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:** _______/________/____________

## CANCELLATION POLICY

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

►**Patient Signature:** ____________________________________________ ► **Date:** _______/________/____________

## HIPAA PRIVATE PRACTICE FORM

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

►**Patient 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. Andrea Buccino and/or Dr. Connor J. Starr 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:____________________________________________________________