



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.
- It is important to the recovery process that you keep all of your prescribed appointments. Should you need to cancel, kindly give 24 hours advance notice, or a \$25 fee will be imposed.
- 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)



Today's Date _____

Patient Information

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: _____

Marital Status: Single Married Divorced Widowed Other **Date 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

Insurance Co: _____ Phone: (_____) _____ - _____

Subscriber ID #: _____ Group #: _____ Relationship to Patient

Policy Holder's Employer: _____

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

Insurance Co: _____ Phone: (_____) _____ - _____

Subscriber ID #: _____ Group #: _____ Relationship to Patient

Policy Holder's Employer: _____

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)



Medical History

| | Yes | No | | Yes | No | | Yes | No |
|----------------------|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|-------------------|--------------------------|--------------------------|
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Claustrophobia | <input type="checkbox"/> | <input type="checkbox"/> | Seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| Cardiac Condition | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Problems | <input type="checkbox"/> | <input type="checkbox"/> | Dizzy Spells | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> | Liver Problems | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Allergies | <input type="checkbox"/> | <input type="checkbox"/> |
| Circulation Problems | <input type="checkbox"/> | <input type="checkbox"/> | Vision Problems | <input type="checkbox"/> | <input type="checkbox"/> | Fractures | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Speech Problems | <input type="checkbox"/> | <input type="checkbox"/> | Strokes | <input type="checkbox"/> | <input type="checkbox"/> |
| Osteoporosis | <input type="checkbox"/> | <input type="checkbox"/> | Sensitivity to Heat | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Nervous Disorders | <input type="checkbox"/> | <input type="checkbox"/> | Sensitivity to Cold | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Metal Implants | <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |

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 any medications, or herbal supplements you are currently taking:

Type: _____ Dosage: _____ Type: _____ Dosage: _____
 Type: _____ Dosage: _____ Type: _____ Dosage: _____
 Type: _____ Dosage: _____ Type: _____ Dosage: _____

What body part are we treating? _____ Date of Onset ____/____/____

Are we treating you as a result of a fall? Yes No

Have you fallen more than twice in the last year? Yes No

Describe the history of your present condition. Please provide all important details:

What are your goals or expectations of therapy?

Patient: _____
 Signature: _____

Date of Birth: ____/____/____
 Today's Date: ____/____/____



Appointment Policy

I understand that my doctor prescribed therapy for me and that physical therapy is an ongoing process which requires regular attendance to be optimally effective. I understand that if I am late for my appointment, I may be given the opportunity to reschedule my appointment or to accept an abbreviated treatment for that day. **I understand that if I cancel or no show for 3 consecutive appointments, Jersey Physical Therapy has the right to discharge me from care for being non-compliant with my physician's orders.**

I understand and agree that Jersey Physical Therapy requires 24 hour advance notice of cancellation. If I fail to give 24 hour notice of cancellation or fail to show up for an appointment, I will be subject to a \$25 charge (which is NOT covered by insurance).

I have read and understand the appointment policy.

Signature: _____ Date: ____/____/____
(Parent or Legal Guardian if patient is under 18)

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 change. Upon request, a copy of our revised notice will be made available to you.

I have read and understand the Notice of Privacy Practices.

Patient Name: _____
Signature: _____
(Parent or Legal Guardian if patient is under 18)

Today's Date: ____/____/____



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. Our findings are listed below, precisely as quoted to us by a provider services representative. 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: _____



Insurance and Financial Policy

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 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 companies. 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 understand I will be responsible for any costs or Collection fees, 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: ____/____/____

(Parent or Legal Guardian if patient is under 18)