IPTA Clinical, LLC
3228 Route 27, Suite 2A
Kendall Park, NJ 08824-1524
P: (732) 297-0032 • F: (732) 297-0558

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 $50 fee will be imposed, *which is NOT covered by insurance*.

- We will call your insurance company to verify your coverage and obtain pertinent information about 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)

jersey
PHYSICAL THERAPY

Patient Information

Name _____
First MI Last

Address_____
Street Apt # City State Zip Code

Home Phone#: (_____) _____ -_____ Mobile Number (_____) _____-_____

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

Gender on ID or Insurance card: ☐ Male ☐ Female
Marital Status: ☐ Single ☐Married ☐ Divorced ☐Widowed ☐Other

Emergency Contact: _____Phone (_____) _____-_____

E-mail Address: _____

Employer: _____ Occupation: _____

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

Physician Information

Referring Physician: _____Office Phone (_____) _____-_____

Primary Care Physician: _____Office Phone (_____) _____-_____

Primary Insurance Information

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

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

Relationship to Patient _____

COMMUNICATION

I authorize Jersey PT 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	☐	☐	Mentall Illness	☐	☐
Nervous Disorders	☐	☐	Sensitivity to Heat.	☐	☐	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 than twice in the last year? ☐Yes ☐No
Describe the history of your present condition. Please provide all important details:
_____

_____

_____

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IPTA Consent and HIPAA Form

AGREEMENT TO PAY FOR SERVICES RENDERED It is understood and agreed that you are ultimately responsible for the balance of your account for any professional services rendered. It is also agreed that if insurance denies for any reason all charges will be your responsibility. It is also understood that if, for any reason (NSF check, etc), costs (collection, attorney fees, court costs, etc.) IPTA Clinical ("us") to collect outstanding balance, these will be your responsibility and will be added to your account balance for collection. IF A REFERRAL OR PRESCRIPTION IS REQUIRED BY YOUR INSURANCE, IT IS YOUR RESPONSIBILITY TO OBTAIN ONE AND BRING IT WITH YOU ON YOUR 1ST VISIT. IF YOU DO NOT, ALL CHARGES INCURRED DUE TO INSURANCE DENIAL WILL BE YOUR RESPONSIBILITY.

CANCELLATION/NO SHOW POLICY We understand that there are times when you must miss an appointment due to emergencies or obligations for family or work. We pride ourselves on the personal care that you receive here and expect from us and only schedule patients every 1⁄2 hour. We ask that you please give us a 24hr notice of cancellation so that we may accommodate other patients that we were not able to schedule in that time slot. Failure to provide 24 hour notice of canceling may result in a fee of $50.00.

CONSENT TO TREATMENT I acknowledge that I am voluntarily seeking care from IPTA Clinical. I authorize a licensed Physical Therapist to evaluate to determine a plan of care. I further authorize a licensed Physical Therapist to provide treatment based on an agreed upon plan of care. I acknowledge that there are some risks inherent with Physical Therapy. I understand that I have the right to question any care being provided and refuse recommended treatments. I acknowledge that the Physical Therapist is acting in my best interest, and cannot guarantee that desired results will be obtained.

CONSENT TO MEDICAL INFORMATION When appropriate for my care, I authorize IPTA Clinical, access to medical information from other providers, which includes, but is not limited to, imaging reports, operative reports, and physician notes.

CONSENT TO CARD ON FILE IF APPLICABLE You have the option to provide credit card information which will be kept on file to be used as a form of payment for fees incurred for co-pays, co-insurance and deductibles.

Acknowledgement of HIPAA

I acknowledge that, at my request, I will be offered and receive information about the HIPAA policy.

I authorize IPTA Clinical, to discuss my Physical Therapy care with the following individuals:

Name_____ Relationship _____ Phone number_____

*Signing below designates that I have read, understand, and agree to all of the above.

Signature: _____ Today's Date_____

Patient or Parent/Guardian (If Under 18)