Patient Express Registration

Hands On NJ PT

Today's Date:

Please Fill-Out Entire Form Completely & Legibly.

1. Patient Info

_____ _____ _____ ☐ Male ☐ Female

Last Name First Name Age

_____ _____ _____ _____

Street Address City State ZIP

(_____)_____ (_____)_____ _____

Home Phone Cellular Email Address (Required for New Patient welcome info)

_____ _____ (_____)_____

Occupation Employer Name Phone #

_____ (_____)_____ _____

Emergency Contact Person Phone # Parent/Guardian signature (If patient is a minor)

Social Security # _____ Date of Birth _____/_____/_____ ☐ Single ☐ Married

Work Status : ☐ Currently Employed ☐ Retired ☐ Disable (__ Total or __ Temporary) ☐ Student (__ PT __ FT)

2. Referral Info

How did you hear about us?

☐ Friend or Family ☐ Newspaper
☐ Internet ☐ Other:
☐ Advertisement
☐ Insurance/Directory

☐ Physician/Dentist/Chiropractor/Nurse:

_____
Referring Physician/Person's Name

_____
City State

_____
Phone #

3. Payment Info

I'm interested in_____?

☐ **SELF PAY**
__ Cash, Check, Credit
__ Care Credit
__ Complimentary Massage by paying for Gold/Silver Package

☐ **INSURANCE**
Which insurance you work with?

_____
My Deductible $_____
My Coinsurance/Copay $_____

☐ **WORKERS COMP**
You must have all info provided under "My Conditions…" in Patient Medical History

☐ **LIEN**
Wait until my case settles before paying. I will complete the "Attorney Lien form. Fees may apply.

Client wishing to use insurance:

☐ I am fully aware of the out of network reimbursement process, and I will submit the claim on my own.

Important Company Policies for a Successful Relationship

We strive to provide you the best personalized care available. To make this possible we adhere to a set of very important guidelines. Please read them carefully, initial all the boxes, and indicate your agreement by signing on the bottom of this form.

☐ **Late Policy "10-minutes"**
Being late by more than 10 minutes will require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations are unpredictable. We do not allow appointment overlap because this undeservedly compromises the care of another patient.

☐ **24-Hour Advance Notice Fee**
If you wish to change or cancel an appointment we require a minimum ***24-hour advance notice.*** Anything less will result in a ***$50 fee*** charged to your account. It costs us money to make appointments available to you. Whether you attend or not we still accrue the expenses (for staff wages, rent, etc.). We don't charge you the actual cost for that appointment but rather a mere ***$50 fee***. We do NOT make money with this charge; it's only to act as a deterrent from making last minute changes. Advance notice allows someone else (who needs it) time to reserve it in place of you. Please be courteous and responsible. Thank you.

☐ **Copays are due upon arrival**
If you happen to forget your wallet or checkbook we may still be able to see you upon completion of an "Extension Request" form. This is a "promise-to-pay" form and carries a minimal fee that allows you to keep your appointment.

☐ **No-shows are bad**
If you fail to show for an appointment without notice all future appointments will be removed and a ***full session cost*** is applied to your account. You may re-schedule appointments again on a "first come, first serve basis".

☐ **Cell phones must be shut OFF or silent**
We realize emergencies may arise and therefore allow you to carry your cell phone during your session, however, please be courteous and set to silent mode or turn off. Thank you.

☐ **Children requiring supervision are NOT allowed to attend sessions with you.**
Unless your facility offers child care services, you may not bring children who require supervision with you to your appointment. If your child does not require supervision and is capable of waiting for you quietly then you may bring them. If any disturbance is caused to other patients or staff members you may be asked to terminate your session early and attend to your child.

☐ **Financial Hardship**
If you are experiencing financial difficulties and are unable to afford the cost of our services we have a "Financial Hardship Form" which may be filled-out. If you qualify for financial assistance according to the Federal guidelines, we may legally assist you by waiving or discounting your (patient responsibility) portions of the bill. Ask the front desk person for assistance.

☐ **Important Notice from the Federal Government:**
"It is unlawful to routinely avoid paying your copay, deductible or coinsurance payments…even if your doctor allows it. Unless you complete a "Financial Hardship" form and qualify for financial assistance under Federal Standards, you may NOT routinely evade paying your responsibility portions for medical care as outlines in your insurance plan even if your doctor allows it. You both may be charged for breaking the law. This includes services deemed as" professional courtesy" and "TWIP's – Take what insurance pays". Failure to comply places you in violation of the following laws: Federal False Claims Act, Federal Anti-Kickback Statute, Federal Insurance Fraud Laws, State Insurance Fraud Laws. Failure to comply may result in civil money penalties (CMP) in accordance with the new provision section 1128 A(a)(5) of the Health Insurance Portability and Accountability Act of 1996 [section 231(h) of HIPAA]. Exceptional cases do apply. Please see contact info for more information. Office of Inspector General, Department of Health and Human Services. Contact by phone: 202 619-1343, by fax: 202 260-8512, by email: paffairs@oig.hhs.gov, by mail: Office of Inspector General, Office of Public Affairs, Department of Health and Human Services, Room 5541 Cohen Building, 333 Independence Avenue, S.W., Washington, D.C. 20201, Joes Schaer, Office of Counsel to the Inspector General, 202 619-0089."

We look forward to building a successful relationship with you that lasts a lifetime!

I have read and agree to all the policies listed above. Signature _____

Hands On NJ Physical Therapy

Statement of Privacy Notice

Effective June 1, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations.

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

We may disclose your health information to notify or assist in notifying a family member or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

We may disclose your health information to coroners or medical examiners.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

We may disclose your health information for military, national security, prisoner, and government benefits purposes.

We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.

We may contact you by phone, mail, or email. It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, postcard, invitation, or call your home to invite you to participate in the charitable activity.

In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by us.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us by calling this office at (732) 548-8068. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints about your Privacy rights or how we have handled your health information should be directed to our Privacy Officer by calling this office at (732) 548-8068. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.
If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Hands On NJ Physical Therapy with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment, and health care operations as described in the Privacy Notice.

_____
Patient's Name (print)

_____
Patient's Signature *Date*

_____
Authorized Facility Signature *Date*

Assignment of My Benefits

IMPORTANT: All information must be **completed** or we will NOT be able to do the courtesy of dealing directly with your insurance.

1. Benefit Info

What is your deductible amount? $_____ and Coinsurance %_____ (for the services you are seeking)
Are there any maximums?
If you don't know this information, call the "800" number on your insurance card. The front desk person may be able to assist you.

2. Policy Info

Patient Name:_____ ID #_____ DOB_____
Insurance Policy 1 Name/Number/Group # (if applicable) _____
_____

****IS PATIENT INSURED THROUGH SOMEONE ELSE'S POLICY?*** Give their info here: (otherwise, skip this portion)
- Policyholder Name_____ Date of Birth_____ SSN_____
- Address (if different than Patient)_____
- Relationship to Patient: __ Spouse __ Parent __ Other: _____
- Employer _____ Ph#_____ Claim #_____
- Employer Address _____

Insurance Policy 2 Name/Number/Group # (if applicable)_____
_____

I hereby instruct and direct _____ insurance company to **pay by check made out to the "Healthcare Provider" to the right and mailed to** the address on the right (not mine). If my/this current policy prohibits direct payment to doctor/therapist, I hereby also instruct and direct you to make out the check to me and mail it to the above address for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.	Healthcare Provider info: **Hands On NJ Physical Therapy LLC** **210 Bridge Street** **Metuchen, NJ 08840** **Tel: 732-548-8068** **Fax: 732-548-8069**

This is a direct assignment of my rights and benefits under this policy.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.
I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
I authorize the use of this signature on all insurance submissions.
I authorize the "Healthcare Provider" named above to deposit checks made in my name.
I authorize the "Healthcare Provider" named above to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Dated this _____ day of _____, 20_____.

_____ _____ _____
Signature of Policyholder Witness Signature of Claimant, if other than Policyholder

PRE-EXAM FORM: In order to evaluate your condition fully, please be as accurate as possible. Thank you.

PATIENT NAME:_____ AGE: _____

HEIGHT:_____ WEIGHT: _____

1.	Where is your pain/problem?		
2.	What caused your pain/problem?		
3.	Approximately when did it start?		
4.	List ONE ACTIVITY you are unable to do, that you absolutely want to be able to do again:		
5.	Have you ever had this same (or similar) pain/problem before?	❑ Yes (If yes, when and describe?) ❑ No	
6.	In your understanding, what do you think will make it better?		
7.	How optimistic are you that you'll get better? (circle one)	Not at all……Mildly optimistic……Fairly……Very optimistic……..Extremely	
8.	What are some potential obstacles to you getting better?		
9.	Over the next 30-days, how many hours per week will you commit to getting better?		
10.	What are you expecting from therapy?		
11.	On the scale, circle your worst pain level in the past couple of days:	*Mild* *Moderate* *Severe* 0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10	
12.	List any medications you are taking:		
13.	List all past surgeries with dates:		

Total:

I understand that my candidacy for a rehabilitation program will be dependent upon my ability and willingness to improve. I have answered the questions above honestly and accurately to the best of my ability. The doctor/therapist will determine whether or not I am a viable candidate for a rehabilitation program and that my approval into their program is not guaranteed.

Patient Signature (or guardian):_____ Date: _____

Patient Medical History

My Condition/injury is related to...

- ☐ Auto/Personal Injury
  - Date of accident: _____/_____/_____
- ☐ Work Injury
  - Date of injury: _____/_____/_____
  - Your company HR person name _____
  - Insurance adjustor name _____
  - Insurance adjustor PH# _____

Have you had any of the following medical or rehabilitative services for this injury/episode?

	Yes	No
Chiropractor		
Massage Therapy		
Occupational Therapy		
Physical Therapy		
Home Health Care		

	Yes	No
CT scan		
EMG		
MRI		
X-rays		

Which of the following have you seen for this condition/episode?

	Yes	No
Podiatrist		
General Practitioner		
Neurologist		
Orthopedist		

Do you now have, or have you ever had, any of the following conditions?

	Yes	No
Asthma		
Emphysema		
Shortness of Breath		
Chest pain		
Coronary heart disease / angina		
Pacemaker		
High Blood Pressure		
Heart Attack		
Stroke / TIA		
Blood clot / emboli		
Epilepsy or Seizures		
Infectious disease		
Diabetes		
Cancer		
Arthritis		

	Yes	No
Osteoporosis		
Gout		
Sleeping problems		
Bowel or bladder problems		
Severe or frequent headaches		
Vision difficulties		
Hearing difficulties		
Numbness or tingling		
Weakness		
Unexplained weight loss		
Allergies		
Pins or metal implants		
Joint replacement		
Dizziness or fainting		
Are you pregnant?		
Do you smoke?		

What sports / Recreational Activities do you participate in?

_____

_____

_____

Patient Signature: _____