Patient Information

Last Name:____________________First Name:________________MI:____ Date:________

Primary Phone:__________________________home / cell

Secondary Phone:________________________home / cell

E-mail:_________________________________

Age:_______DOB:_____________Sex:_________SS#:__________________

Address:_________________________________ City:_________________ State:________

Responsible Party *(if different from above)*

Last Name:____________________ First Name:_________________ MI:____

Primary Phone:__________________________home / cell

Secondary Phone:________________________home / cell

E-mail:_________________________________

DOB:__________SS#:__________________

Address:_________________________________ City:_________________ State:________

Employer Information

Name:____________________________________Phone:____________________

Address:_________________________________ City:_________________ State:________

Occupation:_________________________

Emergency Contact

Name:___________________________Relation:______________Phone:_______________

Watchung Hills Physical Therapy, LLC.
76 Stirling Road, Suite 400, Warren, NJ 07059
Phone: 908-251-5888 Fax: 908-251-5903

Reason for Visit:____
How did you hear about us:____

Referring Physician:_______________________________Phone:_______________________
Date of last visit:______________Follow up visit scheduled: No   Yes, date:______________

Primary Care Physician:____________________________Phone:_______________________

Choose one of the following:

□ I am here as a result of an auto accident.
  Date of accident:___________State occurred:______
  ****Please provide our front desk with auto insurance claim information.*

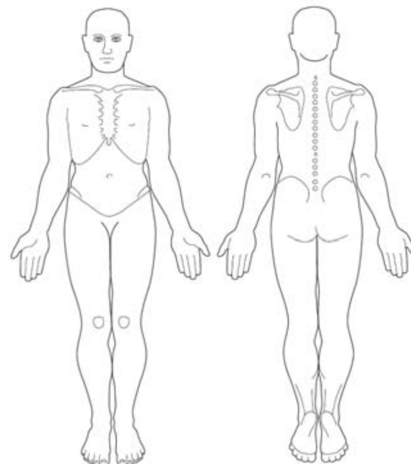
□ I am here because I was injured on the job.
  Date injured:_______________Did you report the injury: No Yes
  Work Comp Insurance Company:____
  Claim#:_____________________Claims Adjustor:____________________________

□ I am here for rehab following a surgery.
  Type of surgery:_________________Date:__________Surgeon:__________________
  Hospital:_____________________________#Nights in hospital:_________________
  Did you have inpatient rehab: No   Yes, # of days/weeks________________________
  Did you have PT at home: No   Yes, # of days/weeks___________________________

□ None of the above.

Date of injury or **onset of symptoms**:____
  What do you think caused your symptoms:_______________________________________
  Have you had these symptoms before: No   Yes, when:___________________________
  Previous treatment:____
  Have you had any imaging for your current symptoms:
    X-rays: No   Yes, results:____
    MRI: No   Yes, results:____
    Other: No   Yes, results:____

Mark on the diagram location of symptoms:
- Use **X** marks where you feel pain
- Use **O** marks where you feel numbness, tingling, or pins and needles



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Intensity: On a scale of 0 to 10, with <u>0 meaning no pain</u> and <u>10 meaning the worst</u> possible pain, circle the number that describes your symptoms:

At its best: 0—1—2—3—4—5—6—7—8—9—10

At its worst: 0—1—2—3—4—5—6—7—8—9—10

Since the onset of your symptoms, have your symptoms:

☐ remained the same ☐ become better ☐ become worse

Circle ***any*** of the following words that ***BEST describe*** your present symptoms:

Dull / Sore / Aching / Tender / Heavy / Flickering / Quivering
Sharp / Stabbing / Lancinating / Piercing / Radiating / Flashing / Shooting
Pulsing / Throbbing / Beating / Pounding / Tiring / Annoying / Nagging
Stinging / Pinching / Cramping / Crushing / Nauseating / Tingling / Itchy
Numb / Tight / Pulling / Hot / Burning / Cold / Cool

Frequency of symptoms *(check best response)*

☐ Constant and intensity of pain doesn't change 24 hours per day

☐ Constant and intensity of pain varies during the day (always some level of pain)

☐ Intermittent (are times when you have no pain at all)

What **increases your symptoms** *(circle all that apply)*
bending / sitting / sit-to-stand / standing / walking / lying / sleeping / turning head
morning / as the day progresses / evening / when still / on the move
Other:____

What **decreases your symptoms** *(circle all that apply)*
bending / sitting / sit-to-stand / standing / walking / lying / sleeping / turning head
morning / as the day progresses / evening / when still / on the move
Other:____

Rate your balance: ☐ Excellent ☐ Good ☐ Fair ☐ Impaired ☐ Poor
Any history of falls: No Yes:____

Exercise habits/Recreational activities:______________________________________

Occupation:____________________Hours worked per week:__________
Activities during work (sitting, standing, lifting, etc):________________________________

What are your **specific goals** for physical therapy:________________________________
____

Medical History

	No	Yes	Please Explain
Allergies			
Fever/night sweats			
Unexplained weight loss or night pain			
Dizziness, loss of consciousness, vertigo, ringing in ears, nausea			
Difficulty swallowing			
Head injury			
Seizures			
Frequent headaches			
Urinary frequency, initiating or controlling bladder, constipation, diarrhea			
Heart disease, high blood pressure, chest pains, heart attack, stroke			
Shortness of breath, asthma, coughing, wheezing			
Cancer, tumors			
Arthritis, rheumatism, osteoporosis, gout			
Diabetes or hypoglycemia			
Thyroid problem			
Blood disorders, anemia, bruise easily			
Tuberculosis			
Ulcers, stomach disorder			
Hepatitis			
Lyme disease			
Liver disease			
Skin (rashes, skin lesions, change in moles)			
Eye disease, blurred vision			
Difficulty hearing, ear pain			
Nasal congestion, bleeding, discharge			
Any chance you are pregnant or trying to get pregnant			
Psychiatric (depression, anxiety, suicidal thoughts or attempts)			

Past Surgeries:____

Past Orthopedic Injuries (sprains, fractures, etc):____________________________________

Any other relevant medical history your therapist should be aware of:____________________

Current Medications Taking:____
____

All information listed above is accurate as of today's date and I agree to notify Watchung Hills Physical Therapy, LLC of any changes in my medical status in the future.

____________________________ ________________________ _________________
Patient/Guardian Printed Name Signature Date

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Patient Name:___________________________

Patient Policies and Consent for Assessment and Treatment Procedures

- Payment is due at the time of service (this includes all copays, coinsurance and deductibles when submitting to insurance).
- Watchung Hills Physical Therapy, LLC will submit necessary paperwork to your insurance carrier, however the patient is responsible for all unpaid amounts billed to the insurance company.
- I authorize Watchung Hills Physical Therapy, LLC to submit all necessary information and claims necessary for payment form the patient's insurance carrier.
- All payments made from your insurance carrier are to be made payable to Watchung Hills Physical Therapy, LLC.
- If payment is sent to patient from the insurance company, patient will turn payments over to Watchung Hills Physical Therapy, LLC immediately.
- Patient will be responsible for any and all deductibles, copays and coinsurances not covered by the insurance carriers for all in-network and out-of-network carriers. This includes all automobile and workers compensation insurances.
- A $65 fee will be charged to the patient for all visits for which the patient no-shows or cancels without 24 hours' notice.
- No guarantees have been made to me about the outcome of my physical therapy care.
- I understand that there are inherent risks involved when performing physical therapy and exercise although these risks have been shown to be minimal.
- I authorize Watchung Hills Physical Therapy, LLC to release information regarding my medical history, treatment, examination results, progress and diagnosis to my physician, other health care providers involved in my care and any third party payor.
- I acknowledge that I have received and/or read a copy of the Privacy Practices for Watchung Hills Physical Therapy, LLC and I consent to the use of my personal health information for the purpose of treatment, payment and health care operations.
- If my account is sent to an outside collections agency, I will be responsible for all fees associated with collecting my account plus a $200 administrative fee payable to Watchung Hills Physical Therapy, LLC.
- I hereby authorize Watchung Hills Physical Therapy, LLC through its appropriate personnel, to perform, or have performed upon me, or the above named patient, such assessment and treatment procedures as are deemed necessary.
- I hereby acknowledge that if this injury is in any way related to a motor vehicle accident or an accident that happened at a workplace that I have informed the staff of this situation.

Patient's printed name: ________________________________

Patient's Signature: ___________________________________ Date: _______________

Witness printed name: _________________________________

Witness Signature: ____________________________________ Date: _______________

Patient Name:___________________________

Medicare Patient's only
Medicare Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to Watchung Hills Physical Therapy, LLC for any services furnished to me by them. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Beneficiary printed name: ___________________________________

Beneficiary signature: _______________________________________ Date: ____________

Supplemental/Secondary Insurance Signature on File

I request that payment of authorized Medicare Supplemental benefits be made on my behalf to Watchung Hills Physical Therapy, LLC for any services furnished to me by them. I authorize any holder of Medicare information about me to release any information needed to determine these benefits payable for related services.

Beneficiary printed name: ___________________________________

Beneficiary signature: _______________________________________ Date: ____________

- All Medicare patients will have to satisfy their deductible and this is their responsibility.
- Watchung Hills Physical Therapy, LLC will submit your claims to Medicare.
- Medicare will cover 80% of allowable charges after your deductible is met.
- Watchung Hills Physical Therapy, LLC. will not submit to your secondary insurance. Please make sure that you have the rollover program Medicare provides. This allows Medicare to submit to your secondary insurance.
- If you do not have the automatic rollover to your secondary you must call your secondary insurance carrier and advise them that you want to be enrolled into the automatic crossover program that Medicare provides. Our insurance company will contact Medicare's Coordination of Benefits Department and provide them with the necessary insurance information. This is a free benefit to all Medicare patients.
- If Medicare does not submit to your secondary and/or tertiary insurance you are responsible to do so after paying any unpaid balances to Watchung Hills Physical Therapy, LLC.
- Patients will be responsible for all deductible, copay's and coinsurances.
- Medicare sets a cap to outpatient physical therapy benefits each year and I agree to pay all balances if my cap has been met and further therapy was performed.

Patient's printed name: __________________ Signature: _________________ Date: __________

Patient Name:___________________________

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THEIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY AND CONFIDENTIALITY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US

LEGAL RESPONSIBLILITY

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice is in effect and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We will use and disclose your protected health information about you for treatment, payment, and health care operations. Following are examples of the types of uses and disclosures of your protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

TREATMENT

We will use and disclose your protected health information to provide, coordinate or manage your health care and any related service. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose of treat you. In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g. a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

PAYMENT

Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provides to you for protected health necessity, and undertaking utilization review activities. Your protected health information will be used in order to collect payment through any other third party or a collection agency.

Patient Name:___________________________

HEALTH CARE OPERATION

We may use or disclose, as needed, your protected health information in order to conduct certain business and operational activities. These activities include but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to write in your name. We may also call you by name in the waiting room when it is your scheduled time. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g. billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice/facility and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact us to request that these materials not be sent to you.

USES AND DISCLOSURES BASED ON YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health care information except as described in this notice.

OTHERS INVOLVED IN YOUR HEALTH CARE

Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

If you want more information about our privacy practices or have questions or concerns please contact us.

I acknowledge receiving the Notice of Privacy Practices for Watchung Hills Physical Therapy, LLC.

______________________________ ____________________

Name (printed) and Signature **Date**