Back In Motion Physical Therapy Patient Intake Information

PATIENT INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

First Name:	Last Name:	Middle Initial:	Date: / /
Address:	City:	State:	Zip:
Birth date: / /	Age:	☐ Male ☐ Female	S.S. #: - -
Home Phone: ( ) -	Alternative Phone (Cell, Pager): ( ) -	Spouse:	

Chose Clinic Because/ Referred to Clinic By ☐ Dr.: ☐ Insurance Plan ☐ Family ☐ Friend

☐ Former Patient ☐ Close to Work/Home ☐ Website ☐ Yellow Pages ☐ Street Sign ☐ Other:

WORK INFORMATION

Employer:	Occupation:	Work Phone ( ) -	Ext.
Address:	☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed		

CARE PROVIDER INFORMATION

Referring Dr:	Referring Dr. Phone: ( ) -
Regular Dr./PCP	Regular Dr./PCP Phone: ( ) -

INSURANCE INFORMATION ***EMAIL ADDRESS:**______________________________

Primary Insurance Name:	S.S.# - -	Are you on cobra? ☐ Yes ☐ No
Subscriber's Name (If different):	Birth date : / /	If yes, When it'll end? / /
ID #:	Group/Policy #	Did you have any PT. this year?
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:		☐ Yes ☐ No If yes, where?
Secondary Insurance Name :	S.S.# - -	....
Subscriber's Name:	Birth date : / /	How many did you used?
ID. #:	Group/Policy #	......................................Visit(s)
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:		

AUTO OR WORK INJURY CLAIM

Insurance Name: ☐ Auto :	☐ (Worker comp) Labor & Industries:		
Adjuster/Claim Manager:	Phone:	Ext.:	
Address:	City:	State:	Zip:
Claim #:	Accident Date: / /	Cause:	

ATTORNEY INFORMATION

Name:	Law Firm:	Phone: ( ) -	
Address:	City:	State:	Zip:

IN CASE OF EMERGENCY

Name of Local Friend or Relative (Not Living at Same Address):

Relationship to Patient:	Home Phone: ( ) -	Work Phone: ( ) -

I authorize my insurance benefits be paid directly to Back In Motion Physical Therapy. I understand that I am financially responsible for any balance and Back In Motion is entitled to collect from me or my legal guardian all the coasts of collection, including attorney fees, paralegal fees, collection agency fees (%) that Back in Motion Physical Therapy PC. Incurs to collect any outstanding invoice amount that is past due in my account. I also authorize __Back In Motion Physical Therapy PC.______ to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE DATE

PAST MEDICAL HISTORY FORM

Patient Name: ……………………………..

BLOOD PRESSURE	YES	NO
Hypertension	☐	☐
Low Blood Pressure	☐	☐
Normal Blood Pressure	☐	☐

HEART DISEASE	YES	NO
Heart Attack	☐	☐
Atherosclerotic Disease	☐	☐
Myocardial Infarction	☐	☐
Rheumatic Heart Disease	☐	☐
Heart Murmur	☐	☐

MUSCLE CONDITION	YES	NO
Carpal Tunnel R/L	☐	☐
Tennis Elbow R/L	☐	☐
Back/Neck Problems	☐	☐
Limited Limb Movement	☐	☐

LUNGS	YES	NO
Asthma	☐	☐
Emphysema	☐	☐
Shortness of Breath	☐	☐

JOINT CONDITIONS	YES	NO
Upper Extremity	☐	☐
Dislocation	☐	☐
Lower Extremity Dislocation	☐	☐

OTHER CONDITIONS	YES	NO
Muscular Dystrophy	☐	☐
Rheumatoid Arthritis	☐	☐
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Gout	☐	☐
Fibromyalgia	☐	☐
Diabetes	☐	☐
Hearing Loss	☐	☐
Poor Eyesight	☐	☐
Fainting	☐	☐
Polio	☐	☐
Cancer	☐	☐
What type?		
Other:		

MEDICAL TEST	YES	NO
MRI TEST	☐	☐
CAT SCAN	☐	☐
X-RAYS	☐	☐

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS		
☐ None	☐ Sitting	☐ Low	☐ Smoking	Packs a Day	_____
☐ 1-2 x Week	☐ Standing	☐ Medium	☐ Alcohol	Drinks a Week	_____
☐ 3-4 x Week	☐ Light Labor	☐ High	☐ Coffee/Soda	Cups a Week	_____
☐ 5+ x Week	☐ Heavy Labor				

What types of exercise do you perform? : ____________________

What things cause stress in your life? :

Are you taking any seizure medication? ☐ YES ☐ NO If yes list name: ____________________

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?

☐ YES ☐ NO If yes list name: ____________________

List all medications you a currently taking: ____________________

List all surgeries in the past two years (Including dates): ____________________

Are you pregnant? ☐ YES ☐ NO What week? ________

Have you had any injuries related to work? ☐ YES ☐ NO If yes list body part and date: ____________________

Have you had any Auto Accidents ☐ YES ☐ NO If yes list body part and date: ____________________

Have you had Physical Therapy or Massage Therapy before? ☐ YES ☐ NO Where:

____________________ ____________________

Signature of Patient, Parent, Guardian, Personal Representative Date

79 Veronica Avenue
Somerset, N.J. 08873

Tel.: (732)246-0665
Fax: (732)246-0776

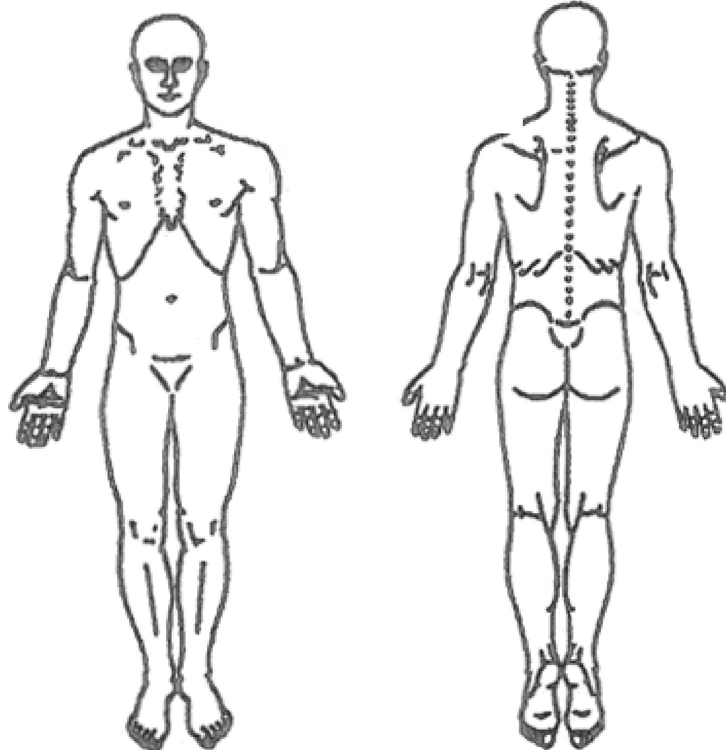
Pain and Symptom Status Report

Name: ____ **Date:** ____________________

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing

Ache	Burning	Numbness
MMM	— — —	O O O O
M	— —	O O O

Pins and Needles	Stabbing	Other
▫ ▫ ▫ ▫ ▫ ▫ ▫ ▫ ▫	/ / / / / / /	x x x x
▫ ▫ ▫ ▫ ▫ ▫ ▫ ▫	/ / / /	x x x



Chief Complaint and Visual Analog Scale

My Chief Complaint is: ____

Date First Symptom of your problem occurred on. ________________

2nd Complaint ____

3rd Complaint: ____

Please circle on the scale below to indicate your CURRENT level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it

Please circle on the scale below to indicate your AVERAGE level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it

Please circle on the scale below to indicate your WORST level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it

Additional Comments ____

____

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PATIENT INFORMATION CONSENT FORM

I have read and fully understand BACK IN MOTION PHYSICAL THERAPY, PC's Notice of Information Practices. I understand that BACK IN MOTION PHYSICAL THERAPY, PC may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that BACK IN MOTION PHYSICAL THERAPY, PC will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in BACK IN MOTION PHYSICAL THERAPY, PC's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

____
Patient Name

____
Signature

____
Date

I also authorize BACK IN MOTION PHYSICAL THERAPY, PC to use my protected health information for targeted marketing, fund raising, and/or solicitation of participation in research studies. I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

____
Patient Name

____
Signature

____
Date

OFFICE PAYMENT POLICY – BACK IN MOTION PHYSICAL THERAPY, PC

It is the policy of BACK IN MOTION PHYSICAL THERAPY, PC, Inc, to collect any moneys due for all applicable deductible, coinsurance, co-pay's and/or self payments on the date services are rendered as indicated as due and payable by the patient's insurance company (if applicable). A receipt will be given for the collection of moneys received in the facility. It is also the policy of BACK IN MOTION PHYSICAL THERAPY, PC, Inc. to assure that all fiscal obligations are satisfactory for the patient and that every effort is made to assure the patient receives the scheduled care without regard to fiscal obligations. Our physical therapy charges are based on the procedures and modalities used and the length of your treatment. Treatments are usually 30, 45 or 60 minutes long. If you are covered by health insurance with physical therapy benefits, we will be happy to bill your insurance. Please provide your insurance information to the office manager and we will verify your coverage as a courtesy.

Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by a physician does not necessarily guarantee that your insurance will cover our services. Please remember that you are 100% responsible for all charges incurred: your physician's referral and our verification of your insurance benefits are not a guarantee of payment. Therefore, we highly recommend you also contact your insurance carrier and check into your coverage for physical therapy. Do not assume that you will not owe anything if you have more than one insurance policy. If you need special arrangements to be made, please discuss this with the office manger before starting your treatments.

Please initial your payment method and sign below that you have read, understand, and agree with all of the information on this page:

______ 1. PRIVATE HEALTH INSURANCE (PPO): Some insurance plans require authorization or a referral from your primary physician. Most insurance plans have a patient responsibility of a deductible (amount paid by the patient before the insurance policy begins payment for services) and either a co-pay (a set dollar amount per visit) or coinsurance (a percent of the allowed charges). Deductibles and co-pays are due at the time of service. We will bill you for coinsurance or other payment due after we have been paid by your insurance or notified of their denial for payment.

______ 2. HMO Insurance: Authorization from your insurance must be obtained prior to treatment. Any co-pay or coinsurance is due at the time of treatment. If your HMO plan also has a Point of Service option you are using, please be sure you understand the difference in your Point of Service coverage verses your HMO coverage.

______ 3. MEDICARE: BACK IN MOTION PHYSICAL THERAPY, PC. is a certified Medicare provider. Medicare has an annual deductible of $100.00 for PT and Speech and a service cap of $1740. Medi-Gap insurance may cover the patient portion due until your Medicare benefits are exhausted. Some insurance plans that are secondary to Medicare cover the patient portion due and services after Medicare benefits are exhausted, but not always. Please verify all of your insurance benefits and be sure you understand your insurance coverage.

______ 4. NO INSURANCE: If you do not have insurance and we do not have administrative costs for your services, you may be eligible for an administrative discount. Please notify the office staff that you do not have insurance so that a payment plan can be discussed.

______ 5. OTHER: Please list the other type of payment: ______________________________

______ 6. WORKER'S COMPENSATION CLAIMS: Authorization from your insurance adjuster is required before you can begin treatment. Please provide the office manager with the name and phone number of your adjuster, the date of your injury and your claim number, and any other pertinent information.

______ 7. THIRD PARTY PAYERS AND AUTO LIENS: We will bill your insurance, however, third party payments will be sent to you for our services, not to us. You are responsible for payment of all service provided. Please be sure to contact this office when your case is settled to ensure your account has been paid. ATTENTION AUTO ACCIDENT VICTIMS AND WORKER'S COMPENSATION INJURY PATIENTS: Please sign a release of information authorizing us to discuss your treatment with your attorney. If you retain an attorney during or after your course of treatment, please inform the office manager of this change. If you plan for your attorney to settle your account with us, you must sign a LIEN agreement. A statement of account will be sent to you or your attorney on a monthly basis until the account is paid.

I have reviewed this office policies statement and discussed it with the clinical office manager. All my questions have been answered to my satisfaction and I understand all the information that has been explained to me.

**I authorize my insurance benefits be paid directly to Back In Motion Physical Therapy. I understand that I am financially responsible for any balance and Back In Motion is entitled to collect from me or my legal guardian all thecoasts of collection, including attorney fees, paralegal fees, collection agency fees (%) that "Back in Motion Physical Therapy PC." incurs to collect any outstanding invoice amount that is past due in my account.

Patient's Signature/ Parent/Guardian Signature : ______________________________Date: ____________

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BACK IN MOTION PHYSICAL THERAPY, PC.

Notice of Privacy Practices
Patient Acknowledgment

Patient's Name: ______________________________ Date of Birth: ____________________

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make certain provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: ____ Date: ________________

Relationship to patient (if signed by a personal representative of patient): ______________________

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NOTICE OF PATIENT INFORMATION PRACTICES

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

BACK IN MOTION PHYSICAL THERAPY'S LEGAL DUTY

BACK IN MOTION PHYSICAL THERAPY is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

BACK IN MOTION PHYSICAL THERAPY uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, we may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

BACK IN MOTION PHYSICAL THERAPY may also use or disclose your personal health information without prior authorization for emergencies, research studies, auditing purposes, and public heath/statistical purposes. We also provide information when required by law. In any other situation, our' policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

BACK IN MOTION PHYSICAL THERAPY may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes. You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. BACK IN MOTION PHYSICAL THERAPY will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that we may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our Privacy Officer at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on our health information practices or if you have a complaint, please contact the following person:

BACK IN MOTION PHYSICAL THERAPY
Attn: Privacy Officer
79 VERONICA AVE.
Somerset, New Jersey 08873