ORTHOPEDIC CARE PHYSICAL THERAPY CENTER, INC.

WELCOME! THANK YOU FOR CHOOSING OUR OFFICE. IN ORDER TO SERVE YOU PROPERLY, WE WILL NEED THE FOLLOWING INFORMATION. ALL INFORMATION WILL BE STRICTLY CONFIDENTIAL.

Please Circle one:

Patient Name: Last:_____ First: _____ MALE FEMALE

Address: _____
Street City State Zip Code

Phone #: Home_____ Work:_____Cell: _____

Email Address: _____ **Are you on active duty in the military for the U.S.? YES NO**

Date of Birth: ____/____/____ **Marital Status: S M W D** **Date of Injury/ Surgery:** ____/____/____

Have you had any Physical Therapy this year? YES NO

How Injured: (Circle One) Job Related Automobile Other (Describe) _____

Patient's Primary Care Physician_____ **Phone#**_____

Patient's Employer: _____ Occupation: _____

Employer's Address: _____
Street City State Zip Code

Spouse's Name: _____**Date of Birth** _____**SS#:** _____

Spouse's Employer: _____ **Spouse's Work#:**_____

Party to notify in case of emergency: _____**Relationship:** _____**Phone #:** _____

Party responsible for patient if patient is a minor: _____ **SS#:** _____

INSURANCE INFORMATION

***PRIMARY INSURANCE*:** Company: _____ Phone#: _____

ID or Claim #: _____Name of Insured _____ Insured's Date of Birth: ____/____/____

WORKERS COMP or AUTO ACCIDENT please fill in the following:

Adjuster's/Rehab Nurse's Name: _____ *Phone #*_____

My signature below acknowledges that the foregoing information, to the best of my knowledge, is complete and correct. I authorize **ORTHOPEDIC CARE PT** to administer treatment as prescribed by my physician. My signature also authorizes assignment of benefits for the treatment rendered to **ORTHOPEDIC CARE PT** and the release of medical information pertaining to my treatment.

_____ _____
Signature Date

Orthopedic Care
Physical Therapy

23-00 Route 208; Fair Lawn, NJ 07410
Phone (201)796-1138 Fax (201) 796-7484
WWW.OCPTC.COM

PAST MEDICAL HISTORY

Patient Name_____Date_____

Emergency Contact – Name & Phone_____(____)_____

FOR THIS PROBLEM/CONDITION: Check the category which applies to your symptoms:

□ Work related injury □ Injury related to falling □ Cause Unknown
□ Auto accident related injury □ Injury related to lifting □ Other_____
□ Recreational/Athletic injury □ Recurrence of previous injury

Have you had these symptoms before? □ Yes □ No
If Yes, are they: □ Getting worse □ The same □ Improving
Have you had: □ Xray □ MRI □ Other Scan If so, approx date_____
Have you had surgery for this condition? □ Yes □No If Yes, approx date_____

LIFESTYLE QUESTIONS:
Are you exercising at the level and frequency that you would like? □ Yes □ No If No, explain_____

List any allergies_____
Are you allergic to nuts or latex? (If so, please specify)_____

List all medications you are presently taking, along with dosage and frequency (or provide list)_____

_____

List major surgery and hospitalizations_____

Do you drink alcohol? □ Yes ____Drinks/Week □ No
Do you smoke? □ Yes _____Packs/Day How many years? ____ □ No
Women: Are you pregnant? □ Yes □ No Do you have menstrual irregularities? □ Yes □ No

OTHER CONDITIONS: Check any that you have or have had

□ Diabetes	□ Osteoarthritis	□ Urinary Leaking with Exercise/Coughing
□ Headaches	□ Heart Attack/Heart Disease	□ Falls or Near Falls
□ Dizziness	□ High Blood Pressure	□ Wound that Doesn't Heal
□ Stroke	□ Asthma/COPD/Lung Disease	□ Change in Vision/Hearing
□ Cancer	□ Circulatory Problem/DVT	□ Calf Pain with Exercise
□ AIDS/HIV	□ Sexually Transmitted Disease	□ Shortness of Breath
□ Pacemaker	□ Metal or Other Implants	□ Chest Pain/Pressure/Angina
□ Seizure Disorder	□ Kidney Disorder	
□ Rheumatoid Arthritis	□ Change in Appetite or Weight	□ Other_____

Therapist Signature_____Date_____

ORTHOPEDIC CARE
PHYSICAL THERAPY CENTER, INC.
23-00 ROUTE 208, FAIR LAWN, NJ 07410

PATIENT INFORMATION CONSENT FORM

I have read and fully understand Orthopedic Care P.T.'s Notice of Information Practices. I understand that Orthopedic Care P.T. may use or disclose my personal health information for the purpose 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 Orthopedic Care P.T. 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 Orthopedic Care P.T.'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.

Individuals are provided the right to request confidential communications or that communications to be made via alternative means, such as sending information to the individual's place of employment instead of their home.

( ) Home Telephone_____
- ( ) OK to leave a detailed message
- ( ) Leave a message with a callback number only

( ) Work Telephone_____
- ( ) OK to leave a detailed message
- ( ) Leave a message with a callback number only

( ) Cell Phone Number _____
- ( ) OK to leave a detailed message
- ( ) Leave a message with a callback number only

_____

Signature Print Name Date

ORTHOPEDIC CARE PHYSICAL THERAPY CENTER, INC
23-00 ROUTE 208
FAIR LAWN, NJ 07410
201-796-1138

ASSIGNMENT OF INSURANCE BENEFITS

PATIENT'S NAME: _____

DATE OF ACCIDENT/ INJURY: _____

In consideration for services rendered to me or to be rendered to me in the future, I hereby authorize payment to the above-referenced provider of any and all insurance benefits to which I may otherwise be entitled for services rendered by the provider.

In the event that the provider's charges are outstanding, I hereby assign and authorize the provider to institute arbitration proceedings or other litigation for the purpose of the provider realizing payment for services rendered. It is also my intent that the provider receive payment directly from the insurance carrier, whether payment is issued prior to or as a result of arbitration proceedings or litigation.

This authorization and assignment or photocopy thereof shall authorize you to furnish all information you may have concerning my condition while under your observation or treatment.

SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____

DATE: _____

ORTHOPEDIC CARE
PHYSICAL THERAPY CENTER
23-00 ROUTE 208
FAIR LAWN, NEW JERSEY 07410

BILLING POLICY

Patient Name: _____

As a service to you, Orthopedic Care Physical Therapy Center will submit your insurance claims.

A phone call will be made to your insurance company to verify the percentage your policy will cover for therapy charges. **THE INFORMATION OBTAINED FROM YOUR INSURANCE COMPANY IS ONLY A GUIDELINE TO INITIATE THE BILLING PROCESS; ORTHOPEDIC CARE PHYSICAL THERAPY CENTER WILL NOT BE HELD RESPONSIBLE FOR ITS ACCURACY.**

Managed Care Patients: **You are responsible to obtain referral forms. Co-pays must be paid at each visit.**
Non Managed Care Patients: **Co-insurance payments (your % due) must be paid weekly**. Any additional portion not paid by your insurance company including deductible and denied or non-covered services will be added to your bill upon notification from your insurance company.
IF YOU ARE A WORKER'S COMPENSATION CASE AND THE CLAIM IS DENIED, YOU ARE RESPONSIBLE FOR FULL PAYMENT. Payments can be made at our front reception desk or by mail; we accept cash, checks and credit cards. A finance charge of 1½% per month will be assessed to all delinquent accounts. If you have any questions regarding your bill, please contact the billing office.

Your insurance policy represents a contract between you and your insurance company. It is your responsibility to know the facts about your coverage. We cannot guarantee that your insurance company will pay all or part of your claim. If you are dissatisfied with their rejection of a claim or with the amount they paid, it is your responsibility to take the matter up directly with your insurance company. Naturally, we will be happy to work with you to provide any and all additional information necessary. **You will be held responsible for your account until it is paid in full.**

FEDERAL/STATE LAW REQUIRES THAT WE INFORM YOU THAT DELINQUENT ACCOUNTS MAY BE PROCESSED BY A COLLECTION AGENCY AT WHICH TIME THEY ARE SUBJECT TO INTEREST CHARGES, COLLECTION CHARGES, AND ALL COUNSEL AND COURT COSTS AS GOVERNED BY FEDERAL AND STATE REGULATIONS.

Your agreed payment for each visit will be_____. You will be balanced billed for your deductible, co-insurance and / or denied services. If the insurance payment reaches 100% all monies are due Orthopedic Care Physical Therapy Center. All payment from primary or secondary insurances sent directly to you must be forwarded to Orthopedic Care Physical Therapy Center.

Signature: _____ **Date:** _____
(IF PATIENT IS A MINOR - PARENT OR GUARDIAN PLEASE SIGN)

ORTHOPEDIC CARE PHYSICAL THERAPY CTR, INC
23-00 ROUTE 208, FAIRLAWN, NJ 07410

NOTIFICATION OF A LAWSUIT

IS A LAWSUIT INVOLVED REGARDING THIS INJURY? YES/NO (CIRCLE ONE)

THEN PLEASE SIGN BELOW WHETHER

YOUR RESPONSE IS YES or NO

The treatment you are to receive from ORTHOPEDIC CARE PHYSICAL THERAPY is as a result of an auto/ liability injury.

If you are pursuing a lawsuit as a result of this accident, please provide the details below;

NAME OF ATTORNEY _____

ADDRESS _____

_____

_____

TELEPHONE _____

FAX _____

Please be aware that for AUTO CLAIMS, involving lawsuits, the daily mandatory auto fee for New Jersey no longer applies when the Auto carrier has denied coverage. When the claims are initially processed any deductible and coinsurance is due at the time of service. The remaining balance will be addressed on completion of the lawsuit.

LIABILITY INJURY lawsuits are initially paid by the primary carrier with any deductible and coinsurance due at the time of service. The remaining balance will be addressed on completion of the lawsuit.

PLEASE SIGN BELOW:

SIGNATURE X _____ DATE _____

(IF PATIENT IS A MINOR- PARENT OR GUARDIAN PLEASE SIGN)

ORTHOPEDIC CARE PT CTR

23-00 RTE 208, FAIR LAWN NJ 07410

CANCELLATION POLICY

TO OUR PATIENTS:

PLEASE BE ADVISED THAT A 24 HOUR NOTICE IS REQUIRED FOR CANCELLATIONS OR AN OFFICE VISIT WILL BE CHARGED.

THANK YOU FOR YOUR COOPERATION

PLEASE SIGN BELOW

_____ DATE: _____

Richard C. Balch, PT
40QA00190000

Orthopedic Care
Physical Therapy

23-00 ROUTE 208 • FAIR LAWN, NEW JERSEY 07410
(201) 796-1138 Fax: (201) 796-7484

HIPAA NOTICE OF PRIVACY PRACTICES

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.

This Notice of Privacy Practices describes how we may use and disclose your Personal Health Information (PHI) to carry out treatment, payment or health care operations for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI, information which includes demographics that may identify you and that relate to your past, present or future physical or mental health conditions and health care services.

Uses and Disclosures of Personal Health Information

Orthopedic Care P.T. uses your PHI primarily for treatment, obtaining payment for treatment, conducting internal administrative activities and evaluating the quality of care that we provide. For example, Orthopedic Care P.T. may use your PHI to contact you to provide appointment reminders, information about treatment alternatives or other health related benefits that could be of interest to you.

Orthopedic Care P.T. may also use or disclose your PHI without prior authorization for public health purposes, auditing purposes, research studies and for emergencies. We also provide information when required by law.

In any other situation, Orthopedic Care P.T.'s policy is to obtain your written authorization before disclosing your PHI. 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.

Individual rights are expanded in important ways. You can ask for a copy of your electronic medical record in an electronic form. Should you decide not to go through your insurance, and pay as you go, you can instruct us not to share information about your treatment with your health plan. The final rule sets new limits on how information is used and disclosed for marketing and fundraising purposes and prohibits the sale of your health information without your permission.

Orthopedic Care P.T. may change its policy at any time. When changes are made, a new Notice of Privacy 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 Privacy Practices at any time.

Patient's Individual Rights

You have the right to review or obtain a copy of your PHI 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 PHI for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your PHI for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Orthopedic Care P.T. 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 Orthopedic Care P.T. may have violated your privacy rights or, if you disagree with any decisions we have made regarding access or disclosure of your PHI, please contact our practice manager at the address listed above. You may also send a written complaint to the U.S. Department of Health and Human Services. For further information on Orthopedic Care P.T.'s health information practices or, if you have a complaint, please contact the following person: Ruthanne Balch, Office Manager.