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 Check one:

Patient Name: Last:______________________ First: _____________________ ☐ MALE ☐ FEMALE

Address: ____

Street City State Zip Code

Phone #: Home___________________ Work:_________________________Cell: _______________

SS#_______/______/__________ **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 in 2012? ☐ YES ☐ NO

How Injured: (Check 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 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 ______________

Have you been treated by: ☐ Physical Therapist ☐ Chiropractor ☐ Other ______________
Check any that you have problems performing: ☐ Standing ☐ Walking ☐ Lifting ☐ Bending
☐ Driving ☐ Up from chair ☐ Other ______________
Is your sleep affected? ☐ Yes ☐ No If Yes, explain ______________

LIFESTYLE QUESTIONS

Are you exercising at the level and frequency that you would like? ☐ Yes ☐ No If No, explain ______________
____

List any allergies ______________________________

List medications you are presently taking (or provide list) ______________________________
____

List major surgery & hospitalizations ______________________________
____

Do you drink alcohol? ☐ Yes ☐ No _____ Drinks/Week
Do you smoke? ☐ Yes ☐ No _____ Packs/Day How many years? ______
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	☐ Falls or Near Falls
☐ Pacemaker	☐ Metal or Other Implants	☐ Chest Pain/Pressure/Angina
☐ Seizure Disorder	☐ Kidney Disorder	☐ Shortness of Breath
☐ Rheumatoid Arthritis	☐ Change in Appetite or Weight	☐ Other ______________

Therapist Signature ______________________________ Date ______________

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

The treatment you are to receive from ORTHOPEDIC CARE PHYSICAL THERAPY is as a result of an auto injury/ 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. However, the claims are initially processed using the auto fee schedule and 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.

SIGNATURE ______________________________ DATE ____________________
(IF PATIENT IS A MINOR- PARENT OR GUARDIAN PLEASE SIGN)

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 receives 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 PT CTR

2300 RTE 208 FAIRLAWN NJ 07410

<u>CANCELLATION POLICY</u>

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:________________

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