TheraPhysical

118 Outwater Lane Garfield, NJ 07026 (201) 340 4656
623 Ridge Road Lyndhurst, NJ 07071 (973) 955 2190
Info@therphysical.com | theraphysical.net

PATIENT INFO

Please Fill-Out Entire form Completely & Legibly

How did you hear about us? ___ Physician ___ Friend ___ Internet ___ Other

Patient Last Name ___________________________ First Name:____________________ Male____ Female___

Date of Birth: _____/_____/____ Single___ Married___ Social Security Number _______:________:________

Street Address: _________________________________City: ___________________ State: ______ Zip _______

Cell Phone #: __________________ Home Phone #: __________________ Email:_________________________

Emergency Contact: ________________________ Phone #: _________________ Relationship _____________

Referring Doctor: ____ Phone #: _____________________

CONDITION INFO

_____ **AUTO/PERSONAL INJURY** Date of Accident ____

_____ **WORK INJURY** Date of Injury _______________Company HR Person Name/Phone __________________

Insurance Adjustor Name _____________________ Insurance Adjustor Phone#_________________________

______ **NO INJURY** Possible Cause ____

Injured Body Part: ___________________ Surgery:_ __/___/___ Where: _____________

MRI/CT/X-Rays: Ordered By: ___________________ Where at: ______________________When? ___/___/___

Have you received Physical Therapy this Year? N/Y Where? ____

Length of Treatment: ___________ Are you seeing any other specialist? Cardiologist/ Urologist/Other N/Y Any skin conditions? N/Y Open wounds? N/Y

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PAYMENT / INSURANCE INFO

______ **INSURANCE** and would like to _________________ Have you deal directly with them. I will assign my benefits to you by completing "Assignment of Benefits Form" (Fees may apply in some cases).

The following information is required prior to first visit: Coinsurance/copay $ __________________ deductible $_______________________________

_____ WORKERS COMP you must have all Info provided under "Condition Info" Section

_____ CASH _______ CHECK ______ CREDIT

_____ I would like to apply for Payment Plan

______I have an ATTORNEY and would like to __________ wait until my case settles before paying. I would complete the "**Attorney Lien**" Form. Fees may apply.

ATTORNEY INFO

Last Name ____________________________________ First Name:__________________________________

Street Address: _____________________________City: ______________________ State: ______ Zip _______

Phone #: _____________________ Fax #: _________________ Claim #________________________________

Patient Signature ______________________________________ **Date** ________________________________

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IMPORTANT COMPANAY POLICIES

Please read carefully and confirm your agreement by signing the bottom of this page.

10-MINUTES LATE POLICY

Beginning late by more than 10 minutes will required you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellation are unpredictable. We do not allow appointment overlap because this undeservedly compromises the car of another patient.

24-HOUR ADVANCE NOTICE FEE

if you wish to change or cancel an appointment, we require a minimum 24 hours advance notice. Anything less will result in a $10 fee charge to your account. It cost 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 $10 fee. We do NOT make money with this charge; its 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 happened to forget your wallet or checkbook, we may still be able to see you upon completion of an "Extension Request" form. This s a promise-to-pay form and carries a minimal fee that allows you to keep your appointment.

NO-SHOW POLICY

If you fail to show for an appointment without notice all future appointments will be removed and a $10 fee assessed to your account. You may re-schedule appointments again on ta "first come, first serve basis".

CELL PHONES MUST BE SHUT OFF OR SILENT

We realize emergencies may arise and therefor allow you to carry you 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 childcare services, you may not bring children who required supervision with you to your appointment. If your child does not require supervision and is capable of waiting for your

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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 APPLICABLE

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 your quality 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 a copay, deductible or coinsurance payment, even if your doctor allows it. Unless you complete a "Financial Hardship" form and quality for financial assistance under Federal Standards, you may NOT routinely evade paying your responsibility portion for medical care as outlined in your insurance plan even if your doctor allows it. You both may be charge for breaking the law. This included services deemed as "professional courtesy" and "TWIP's – Take What Insurance Pay". Failure to comply places you in violation of the following laws: Federal False Claims Act, Federal Anti-Kickback Status, Federal Insurance Fraud Laws, State Insurance Fraud Laws. Filature to comply may result in civil money penalties (ICMP) 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 o f 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 of human Services, Room 5541 Cohen Building, 333 Independence Ave, S.W. Washington , D.C. 20201, Joel Sheer, Office of Counsel to the Inspector General, 202 619-0089.

Please present all medical insurance cards and a photo ID to the front desk staff and advise if these are not the most current copy or you are expecting to receive newer cards in the near future. We are required to retain photocopies of these in your medical record for health insurance fraud regulation requirements. Thank you for your cooperation!

Patient Signature ____ Date __________________________