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

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

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

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 _____

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

TheraPhysical

24 Hour Appointment Cancellation Policy

TheraPhysical, LLC has a 24-hour cancellation/rescheduling policy.

If appointment is missed, canceled or changed with less than 24 hours' notice, there will be a $10.00 charge.

By signing below, you acknowledge that you have read and understand the Cancelation Policy for TheraPhysical, LLC as described above.

Thank you for understanding and cooperation.

Patient Name (PRINT) _____

Patient Signature _____ Date _____

TheraPhysical

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

Patient Name _____

I irrevocably assign to TheraPhysical, all my rights and benefits under any insurance contracts for payment for services rendered to me by TheraPhysical. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claim by TheraPhysical to be release to TheraPhysical. I irrevocably authorize TheraPhysical to file insurance claim on my behalf for services rendered t me. I irrevocably direct that all such payments go direct to TheraPhysical. I irrevocably authorize TheraPhysical to act in my behalf and report any suspected violation of proper claims practices to the proper regulatory authorities.

I irrevocably authorize TheraPhysical to obtain counsel and enter legal or other action on my behalf and/or in my name, including the arbitration/dispute process, to collect such sums due it should sum not to be paid within the legally prescribed time frame. In the event that TheraPhysical elect to bring a lawsuit of petition for arbitration/dispute resolution their claim for any unpaid bills for services rendered for injuries that I sustained in this or any accident.

In the event that this assignment is held invalid for any reason, I hereby authorized TheraPhysical to appoint an attorney of its choice to represent me directly against an insurer from which I may collect PIP benefits and to bring a claim in a forum of its choice. This appointment is intended on enabling the attorney to collect the bills of TheraPhysical.

The undersigned patient does hereby agree and acknowledge that he/she may receive benefit checks directly form the insurance carrier for services rendered by the provider. The undersigned patient hereby agrees to immediately forward said checks to TheraPhysical, upon receipt of the same.

A photocopy of this assignment shall be valid as the original. This assignment of benefit has been explained to my full satisfaction, and I understand its nature and effect.

Patient Signature _____ Date _____

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

TheraPhysical

PATIENT INFO

Last Name _____ First Name:_____

By my signature below, I am requesting that my doctor, Magdalena Buczek, DPT, reduce normal and customary fees to allow me to receive physical therapy care. My financial circumstances are such that I am unable to pay the customary fees.

I recognized that any agreement made to assist me is purely confidential and that my financial arrangement would be different than that which is standard in this office.

_____ **Patient Initials.** This is a financial hardship agreement not a guarantee of a "cure". No doctor can or should the response of any patient to any treatment.

Patient Signature _____ **Date** _____

Witness Signature _____ **Date** _____

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

Insurance checks sent to the patient

Insurance companies may send checks to the patient for service performed by TheraPhysical. If you receive any checks, do not cash or deposit them. Instead, please endorse the back of the checks and either mail or bring in to the TheraPhysical.

I, _____ have been informed by TheraPhysical that checks for my insurance company may be sent directly to me. I agree to endorsee these checks on the back and mail or bring in to the TheraPhysical. I understand that these checks from my insurance company are for services provided to me.

I agree and acknowledge not to check or deposit these checks. In event that I falsely withhold such check, I understand I am responsible for the amount due to TheraPhysical.

Patient Signature _____ Date _____

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

TheraPhysical Limited Liability Company, Acknowledgement of Disclosures and Request for Out-of-Network Services

I, _____ acknowledge that TheraPhysical Limited Liability Company and the providers listed below are out-of-network with my health insurance plan. I also acknowledge the following disclosures:

- Prior to scheduling my appointment, I was informed that TheraPhysical Limited Liability Company was out-of-network and that the amount or estimated amount to be billed for services is available to me upon request.
- Upon written request, TheraPhysical Limited Liability Company will disclose in writing the amount or estimate amount that it will be bill you for the series and the CPT codes associate with the services (absent unforeseen medical circumstances that may arise);
- May out of network financial responsibilities may be in excess to the copayment, deductible, or coinsurance and I may be responsible for any costs in excess of those allowed by their carrier; and
- I should contact my carrier for further information or consultation on these costs. I should also contact my carrier for more information or consultation on the cost for the services of the coordinated care providers.

I acknowledge that I am knowingly and voluntarily accepting responsibility for any out-of-network financial responsibility associate with the health care services that I receive.

Patient Signature _____ **Date** _____

Patient Name (PRINTED)_____

List of TheraPhysical Limited Liabilities Company Providers

Madgalena Buczek, PT, DPT
Abraham Salamon, PT, DPT
Danielle Griscom, PT, DPT
Gene Yau, PTA

NJ OON LAW DISCLOSURE 8.29.18; #10109760.1

TheraPhysical

PRE-EXAM QUESTIONNAIRE
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

Last Name _____ First Name:_____ Age___ Male____ Female___

Occupation_____ Phone #: _____

IN ORDER TO EVALUATE YOUR CONDITION FULLY, PLEASE BE AS ACCURATE AS POSSIBLE

1. Have you had physical therapy before? No____ Yes ____; When_____
2. Have you had Home Health Care? No____ Yes ____; When_____
3. Where is your pain/injury? _____
4. What caused your pain/injury? _____
5. Approximately when did the pain/injury start? _____
6. Is the pain/injury getting? Worse_____ Better _____ Staying the Same _____
7. Have you ever had this pain/injury before? No ____ Yes____ When _____
8. Is your pain? Constant (never goes away) _____ Intermittent (comes & goes) _____
9. On a scale from zero to ten, circle your worse pain level in the past couple of days

   0 1 2 3 4 5 6 7 8 9 10
10. Are you taking any medication for this pain/injury? No ___ Yes ___What kind, does it help _____
11. Are any of your usual everyday activities affected? No ____ Yes ____ Describe how _____

    _____
12. List all past surgeries with dates _____

    _____
13. List all medical conditions you have _____

    _____
14. Other important information we should know about _____

Patient Signature _____ **Date** _____

INITIAL EVALUATION

Physical Therapist _____ **Initials** _____ **Date** _____

PROTECTED HEALTH INFORMATION
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

First Name _____ Last Name:_____

This notice describes how care information about you may be used and disclosed and how you can get access to this information. Please review it carefully. TheraPhysical office abides by the terms described in this policy.

TheraPhysical office discloses your protected health care information for the following reasons.

1. To share with other treating health care providers regarding your health care
2. To submit to insurance companies or Workers' s comp claim to be verify that treatment has been rendered
3. To determine patient's benefits in a health care plan
4. Releasing information required by State or Federal Public Health Law
5. To assist in overcoming a language matter when caring for a patient
6. Business associated providing written assurances for your privacy have been attained
7. Emergency situations
8. Abuse, neglect or domestic violence
9. Appointment reminders to household members or answering machines
10. Sin-In logs may be disclosed to variety office visits

Any other uses or disclosures will only be made with your specific written prior authorization

You have the right to:

1. Revoke authorization, in writing at any time by specifying what you want to restrict and to whom
2. Speak to our privacy officer ___Ewelina _____regarding privacy issues, and can be reach out at 201 340 4656
3. Inspect, copy and amend your protected health information and amend it as allows by law
4. Obtain an accounting of disclosures of your protected health information
5. To render a complain to our privacy officer or the Secretary of health and Human Services

TheraPhysical office reserves the right to change the terms of this notice and to make new notice provisions for all protected health information that maintains. Patients may also get an updated copy upon request at any time by asking the staff.

I acknowledge that I have received and reviewed this notice with full understanding.

Patient Signature _____ Date _____

TheraPhysical

REGISTRATION
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

TheraPhysical

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

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 _____