PRIME
Physical Therapy & Sports Care

Patient Information

First Name:_____Last Name:_____Date:_____

Address:_____City:_____State:_____Zip:_____

Date of Birth:_____Phone:_____Email:_____

(Check one) __ Male __Female Marital Status:_____

Current Work Status: __Full-Time __Part-Time __Retired __Disabled __Homemaker __Not working

Employer:_____Occupation:_____

Emergency Contact:

Name:_____ Relation to Patient:_____

Phone Number:_____

Referring Physician:_____ Reason for Visit:_____

How did you hear about us? _____

Insurance Information

Primary Insurance Name:_____

Subscriber's Name (if different):_____Birth Date:_____

I.D. #: _____ Group/Policy #: _____

Patient's Relationship to Subscriber (Check one): __Self __ Spouse __ Child __Other

Motor Vehicle or Workers Compensation Cases

__Motor Vehicle __Workers Compensation

Insurance Name:_____ Adjuster/Claim Manager:_____

Phone:_____Ext.:_____Address:_____City:_____

State:_____Zip:_____Claim #:_____Accident Date:_____

Cause:_____

_____ Date:_____

Patient/Guardian Signature

160 White Rd. Suite 104 Little Silver NJ 07739

Appointment Policy & Guidelines

To receive the maximum benefit from your prescribed therapy program and your treatment time in our clinic it is essential to be consistent with your outlined physical therapy program and appointments.

Patient Guidelines:

- Appointments are made on a first come, first served basis. If you require a specific time you may schedule all your prescribed appointments at the time of your initial visit. Otherwise try to schedule your appointments at least one week in advance.
- We understand emergencies arise. If you are unable to keep a scheduled appointment, please call our office as soon as possible. A message can be left on our answering machine 24/7.
- If you are going to be more than 10 minutes late for an appointment, please call our office. Your appointment may need to be rescheduled due to patient volume.
- In order to continue therapy beyond the initial time period you must obtain a new prescription from your doctor. You can do this by calling his/her office for a new prescription or by returning to the doctor's office for a visit. Each doctor has different policies, so in order to avoid gaps in treatment we suggest you contact your doctor at least one week prior to your prescription expiring.

Our Policy:

- We will treat all patients as close to your scheduled appointment time as possible.
- We will try to accommodate your need for specific appointment times.
- We will obtain authorization (pre-certification) from your insurance company if this is a requirement of your policy.
- Third party payors (workers' compensation carriers) will be notified of a patient's failure to attend scheduled appointments in the event of a no-show, or a cancellation without rescheduling in the same week.

Cancellation Policy:

- If a patient cancels a scheduled appointment within 24 hours of the appointment, and/or does not inform PRIME PHYSICAL THERAPY & SPORTS CARE, the patient will be responsible for a charge of **$30** per visit.
- **PRIME PHYSICAL THERAPY & SPORTS CARE, reserves the right to discharge any patient who repeatedly cancels or does not show for his/her scheduled appointments.**

_____ Date:_____

Signature

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Payment

PRIME PHYSICAL THERAPY & SPORTS CARE requires payment at the time of service. This includes deductibles and co-payment obligations that have been set up with the patient, as well as charges per visit for private-pay patients. Additionally, many insurance companies have additional stipulations that may affect your coverage, or your treatments may be denied for any reason. Payment for any services not covered is required within 15 days of being billed.

I have read the above guidelines and policy regarding my financial responsibility to PRIME PHYSICAL THERAPY & SPORTS CARE, for providing services to me, (or the above named patient). I authorize my insurer to pay any benefits directly to PRIME PHYSICAL THERAPY & SPORTS CARE. In the event that my insurance company sends the check directly to me, I will immediately endorse and remit the check to PRIME PHYSICAL THERAPY & SPORTS CARE.

_____ Date:_____

Patient/Guardian Signature

I understand and agree (regardless of my insurance status): I am financially responsible for my account for any professional services rendered that are not otherwise paid or reimbursed. I hereby authorize my insurance company to assign my benefits directly to PRIME PHYSICAL THERAPY & SPORTS CARE if benefits are payable to me. I also agree to be responsible for payment of services rendered on behalf of my dependents. I understand and agree that should my account be turned over to a collection agency, I may be responsible for up to an additional 32% of the unpaid balance.

_____ Date:_____

Patient/Guardian Signature

Consent for Treatment

Name: _____

I hereby authorize PRIME PHYSICAL THERAPY & SPORTS CARE to perform or have performed upon me, or the patient named above, assessment and treatment procedures that are deemed medically necessary and appropriate in the scope of practice of a licensed Physical Therapist.

_____ Date:_____

Medical History

Name_____ Date of Birth_____

Have you had surgery for this injury? YES NO
Type of Surgery (if applicable)_____

Have you had any hospitalizations in the past year? YES NO
If YES, please explain_____

Height_____ Current Weight_____

Please indicate (circle) if you had a: MRI X-RAY EMG/NCV Injection Other
Results?_____

Pain level: (please circle) 0 1 2 3 4 5 6 7 8 9 10

Medical History (check all that apply)

	YES	NO		YES	NO
Hypertension	___	___	Gout	___	___
Low Blood Pressure	___	___	Diabetes	___	___
Heart Attack/MI	___	___	Vision/Hearing loss	___	___
Coronary Heart Disease	___	___	Infectious Diseases	___	___
Heart Murmur/Arrhythmia	___	___	Do you smoke?	___	___
Pacemaker	___	___	Are you pregnant?	___	___
DVT	___	___	Allergies	___	___
Stroke/TIA	___	___	Other	___	___
Numbness or Tingling	___	___	Surgeries/Injuries:		
Osteoarthritis	___	___	Foot/Ankle/Leg	___	___
Osteoporosis	___	___	Back/Neck	___	___
Asthma	___	___	Shoulder/Elbow	___	___
COPD					
Cancer	___	___	Wrist/Hand	___	___
Rheumatoid Arthritis	___	___	Any pins/metal implants	___	___
Multiple Sclerosis	___	___	Fractures	___	___
Epilepsy/Seizures	___	___	Other	___	___
Parkinson's Disease	___	___			

Please provide any additional information on those marked YES, or that will assist us in providing you care:_____

Please list all current medications: _____

_____

Patient/Guardian Signature:_____ Date:_____

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HIPAA Policy (Privacy Act)

This notice summarizes how medical information about you may be used and disclosed by our staff. PLEASE READ IT CAREFULLY.

The following is a brief summary with regard to how your protected health information (PHI) may be used by Prime Physical Therapy & Sports Care:

1. We CAN release your PHI to your referring physician to update him/her with regard to your condition/progress in treatment
2. We CAN use your PHI to submit claims to your private insurance carrier for services rendered, including workers' compensation and motor vehicle insurance carriers. We CAN also use your PHI to collect outstanding balances using a third party collector, if necessary.
3. We CANNOT release any PHI to anyone else without your authorization. We are unable to give information to a spouse, any other relative, or significant other without your specific written consent allowing us to do so. If the patient is a MINOR child, then the PHI can be given to the child's parent/guardian without the child's authorization.
4. If your treatment is related to a legal matter of any kind, your attorney must provide our office with a release signed by you, allowing us to provide treatment information to him/her.

You may release my PHI and/or discuss my condition/treatment with:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

_____ _____

Signature (as to HIPAA Policy) Date

PRIME
Physical Therapy & Sports Care

Would you like to receive appointment reminders from Prime Physical Therapy & Sports Care?

- ❑ YES
- ❑ NO

If yes, how would you like to receive reminders?

❑ Email Email Address:_____

❑ Text Message Cell Phone Number:_____

Please Circle Cell Provider:

- AT&T
- Verizon
- T-Mobile
- Sprint
- Boost Mobile
- Metro PCS