Raising the Standard for Optimal Care

Spectrum Physical Therapy & Athletic Training

Video Surveillance Acknowledgement Form

To protect the safety of our patients, staff, and visitors at Spectrum Physical Therapy and Athletic Training, the office and common areas of the clinic monitored and recorded via video surveillance 24 hours a day, seven days a week.

Private areas such as restrooms, treatment rooms and areas with curtains will never be under surveillance or recorded.

By signing this form, I am acknowledging that I am aware that I am under video surveillance and my actions may be recorded 24 hours a day, seven days a week, when I am in the common areas of the clinic.

_____
Patient Signature

_____
Print Patient Name

_____/_____/_____
Date

SPECTRUM Physical Therapy & Athletic Training, LLC

1203 River Rd. Suite 4
Edgewater, NJ, 07020
Ph: (201) 937-3600
Fax: (201)731-5192

&

180 Old Tappan Rd. Bldg 6
Old Tappan, NJ, 07675
Ph: (201) 768-2000
Fax: (201)731-5192

Email: spectrum@spectrumptat.com
www.spectrumptat.com

Patient Information

Patient Name _____

Date of Birth _____/_____/_____ Male ☐ Female ☐ Decline to Specify ☐

Address _____

_____

Telephone (_____)_____-_____ (Cell) (_____)_____-_____ (Home)

Email _____

Referring Doctor: _____

Prescription Present: Yes ☐ No ☐ Date of Prescription: _____/_____/_____

*Please be aware, NJ State regulations require a doctor's prescription after 30 days. We do prefer that the prescription be present at the initial visit, however, if you are visiting us without a doctor's prescription you will be responsible for getting a prescription after 30 days.

Condition/Injury: _____

Date of accident/injury: _____/_____/_____

Have you had Surgery: Yes ☐ No ☐ If Yes: Date of Surgery: _____/_____/_____

Are you currently receiving home health care services? Yes ☐ No ☐

Please check off if any of the following apply to your condition/injury:

Auto ☐ Insurance Carrier: _____ State: _____

School/Sport ☐ HS ☐ College ☐ Name of School: _____

Worker's Comp ☐ Employer: _____

State: _____

Employer Address: _____

_____

Primary Insurance: _____

Insured Party (Primary Insurance holder): _____

Relationship To Patient _____Date of Birth _____/_____/_____

Secondary / School Insurance (if applicable):_____

By signing below, I am authorizing Spectrum Physical Therapy & Athletic Training LLC to treat me as per my doctor's prescription and to release to my insurance company/attorney/employer any information concerning my health care, advice, treatment, or supplies.

Signature:_____ Date:_____/_____/_____

Guardian/Parent Signature (under 18):_____ Relationship:_____

Health Insurance Benefits

Patient Name:_____

As of _____/_____/_____ your healthcare insurance benefits are as follows:

IN NETWORK BENEFITS

Deductible_____/ Met _____

Copay _____

Coinsurance _____

Out of Pocket _____/Met _____

OUT OF NETWORK BENEFITS

Deductible_____/Met _____

Copay _____

Coinsurance _____

Out of Pocket _____/ Met _____

Referral Required _____ Prescription Required _____ Authorization Required _____

Our office has verified your benefits; details of this information are listed above. This information is not guaranteed and may change as claims are processed. Patients are responsible to understand the contract they have with their health insurance carrier.

In the event that your physical therapy benefits are exhausted, or your health insurance does not cover your visits, patients will be charged $125 for the initial evaluation and $80 per follow up visit.

*Copays are due at the time of service.

*Deductibles and coinsurance will be balance billed.

Are you currently involved in a lawsuit for your injury that will prohibit us from billing your medical insurance? Yes ☐ No ☐

_____ _____/_____/_____

Signature Date

If you have any questions regarding this information, or general billing questions, please contact the billing manager at 917-564-1340

Thank you for selecting our physical therapy practice. We look forward to providing you with the highest level of therapy care. At our practice you will be receiving one-on-one treatment with our therapists, supervised exercises as well as given exercises that can be performed at home to help speed up recovery time. Each of our staff members are committed to aiding in your therapy treatment and providing each of our patients with the utmost satisfactory care. Please review our terms below carefully, explaining our policies and procedures regarding our fee arrangements and billing methods. If you have any questions regarding these terms, please do not hesitate to contact our Administration Staff.

1. **Fees.** If you have insurance, please present your valid insurance card at your first visit. As a courtesy we will bill your insurance company for all covered services. However, you will be responsible for paying all co-pay, co-insurance and deductible amounts at the time services are rendered. In addition, you will be responsible for paying the costs associated with all non-covered services including, without limitation, providing third parties with medical records and information regarding your care as requested. Before your appointment, we perform a Benefits and Eligibility check to determine your physical therapy health insurance benefits. However, we strongly recommend all our patients perform the same check on their own since Spectrum cannot be held responsible for false or incorrect information provided by your insurance carrier. If you have a secondary health insurance carrier whom you would like to cover your copayment or coinsurance, it is our policy that we still collect those funds from you at the time of your visit. However, we are happy to provide you with the necessary information you need to submit that claim on your own. We also charge $100.00 for copying medical records and completing forms for your work or school.
2. **Billing Statements.** Statements are sent on a monthly basis; your bill will include a description of services performed and any payment made by your insurance company. Your balance is due and payable in full immediately upon receipt of your statement. It is company policy with all patients, to have your credit card or debit card information on file. We do not make exceptions regarding this policy. By signing below, you agree to allow us to charge your credit card the outstanding account balance not paid within thirty (30) days of receipt of the invoice or if your invoice is returned to us as undelivered. Additional processing fees may apply. Further, you agree to pay us for any expenses (including legal fees) we incur in connection with the collection of your past due account. If you should ever have a question about a billing statement or our billing procedure, you should contact us within thirty (30) days of the invoice date; otherwise, the billing statement is acceptable as presented. For your convenience, you can use your credit card to pay your bill over the telephone or online.
3. **Cancellations**. Please notify us at least 24 hours in advance if you need to cancel or change your appointment. If a cancellation or change is made with less than 24 hours' notice, spectrum then reserves the right to charge a $50.00 fee.
4. **Our Commitment.** Our Therapists regard their relationships with patients as an inviolable trust based on respect, compassion, and concern for good health. We are proud of our high standard of work, and care how our patients feel about the services we provide. Patient satisfaction and confidence that our practice provides the highest level of care is at the core of our service commitment. If at any time you, as a patient of our practice, do not feel we are living up to this commitment, please notify us promptly.

By signing below, I agree to having read, reviewed, and agreed to the terms Spectrum Physical Therapy and Athletic Training LLC

_____ _____ _____/_____/_____

Print Name Signature Date

Credit Card Information:

Type: (Circle one) Master card Visa American Express Discover

_____ _____ /_____

(Credit Card Number) (Exp. Date)

_____ _____

(Name on card) (CVV- Security Number)

Conditions of Admission to

Spectrum Physical Therapy & Athletic Training, LLC. Outpatient Services

1. CONSENT TO TREATMENT: I understand that I am being admitted for treatment to an outpatient department of Spectrum Physical Therapy & Athletic Training, LLC. ("Spectrum"), an acute care rehabilitation center. Consent is hereby voluntarily given to Spectrum and to all health care professionals using its facilities to provide comprehensive and therapeutic treatments and/or evaluations that, in the judgment of the appropriate healthcare professionals, are necessary for the health and welfare of the above-named patient.
2. Absent emergency or extraordinary circumstance, no substantial procedures will be performed upon me unless and until I have had an opportunity to discuss them with the physician or other health professional to my satisfaction. I or my representative will be informed of the nature of the particular procedure or treatment which a physician in a similar circumstance would reasonably disclose, which would provide a reasonable individual; with a general understanding of the procedure or treatment, possible alternative procedures and treatments and substantial risks inherit in the proposed procedure and which a patient in my circumstances would consider relevant in making a decision concerning whether to undergo the treatment or procedure.
3. RESEARCH: Research to improve patient care is conducted at this clinic and is approved and monitored by members of Spectrum. This review and monitoring assures strict confidentiality with regard to who may view medical records. I consent to the use of information in my record for research purposes. I understand that I might subsequently be asked if I would be willing to participate in research projects if they require activities outside of normal clinical care, and that I have the right to decline participation.
4. RELEASE OF INFORMATION: I understand and agree that Spectrum may disclose all or any part of a patient's record in order to obtain payment of all or a part of Spectrum's charges. This disclosure may be made by Spectrum to any person or corporation which is or may be liable under a contract with Spectrum, the patient, a family member or employer of patient, including but not limited to insurance companies, governmental agencies (including Medicare and Medicaid), worker's compensation carriers, welfare funds, the patient's employer and other third-party payors. I understand and agree that Spectrum may disclose all or any part of patient's record to other providers of health care services or goods in order to make arrangements for coordinated health care delivery. I understand and agree that the information, which Spectrum may disclose, may include information about and/or reference to HIV/AIDS related diagnoses/conditions, drug and alcohol use or abuse, pain management, and psychiatric or psychological information, reports, evaluations and diagnoses, as well as evaluations, consultations, and treatment recommendations. Spectrum may disclose medical information about a patient to the patient's physician (noted in the admission record), and to: Spectrum personnel who are authorized to disclose patient information include members of the medical records department, finance department, and clinical personnel (Including physicians, nurses, therapists). I understand that I have the right to change my mind regarding release of information from my medical record at any time, by sending a written notice to the Director of Medical Records but this will not affect information, which has already been released. I am aware that confidential communications between a patient and a licensed psychologist/ psychiatrist are protected by statutory privilege accorded by section 28 of the Public Law 1966, chapter 282 to confidential communications between a patient and a licensed psychologist/ psychiatrist and cannot be released without my consent If I do not notify the Director of Medical Records that I am revoking this consent to release information, this consent will terminate one (1) year after payment in full has been made to Spectrum for all goods and services provided to me.
5. In the event of a health care worker's accidental exposure to my blood or other body fluids. I hereby authorize the clinic with the assistance from personnel certified to take blood, to draw a blood sample for the presence of blood borne pathogens, including HIV (AIDS), and/or Hepatitis B or C The results of such tests will remain confidential.
6. PERSONAL RESPONSIBILITY: In the event that payment from my insurance companies and/ or benefits plan is insufficient to cover the cost of my treatment at the clinic, I understand that if no payment is made by the insurance companies and/or health benefit plans, I am responsible for payment of the entire charge for treatment provided during visits to the Spectrum clinic. I understand that if I do not pay the entire balance within (30) thirty days after the date I may be billed, a charge of one percent (1%) of the total balance on the account may be added to the account for that billing period and each month thereafter until the balance is paid in full. I further understand that in the event that Spectrum retains the services of a collection agency or an attorney due to my failure to pay the balances due within (30) days after a demand for payment, that I am responsible for the actual costs incurred by Spectrum for these services, not to exceed thirty percent (30%) of the total outstanding balance on the account.
7. I authorize Spectrum to apply and credit any overpayment made to Spectrum which would be payable to me against any balance owed to Spectrum for which I am the responsible party. I irrevocably assign to Spectrum all the right, title, and interest in benefits payable for injuries to me which are being treated by Spectrum out of any claim or third party action against any other person, entity, or insurance company or out of any recovery under the uninsured motorist provisions or the medical payment provision of any insurance policies under which I may be entitled to recover for injuries which are being treated by Spectrum. Co-payments are due at the time of service.
8. I acknowledge receipt of the Spectrum Notice of Privacy Practices and Patient's Rights.

This form has been fully explained to me and I certify and acknowledge that I understand its contents and agree to its terms and provision.

_____ _____

Print Patient Name Signature

_____ _____/_____/_____

Signature of parent or guardian (if under 18) Date

Outpatient Medical History/Screening Form

Patient Name:_____ Preferred Language:_____

Emergency Contact:_____ Telephone #:_____

Family Physician/ Internist:_____ Telephone #:_____

Religious/Cultural Needs: **NO** **YES** If yes, please explain: _____

Special Learning Needs: **NO** **YES** If yes, please explain: _____

Medical Information

To the best of your knowledge, please check off any of the following that you have had in the past or have presently.

	YES	NO		YES	NO
High Blood Pressure	☐	☐	Spinal Cord Injury	☐	☐
Chest Pain/Angina/Heart Attack	☐	☐	Traumatic Brain Injury	☐	☐
High Cholesterol	☐	☐	Stroke	☐	☐
Pacemaker	☐	☐	Fractures	☐	☐
Emphysema/Asthma	☐	☐	Date: / / Area of fracture:		
Shortness of breath	☐	☐	Date: / / Area of fracture:		
Fainting disorders	☐	☐	Concussion	☐	☐
Hepatitis	☐	☐	Osteoporosis	☐	☐
Bleeding/Bruising	☐	☐	Multiple Sclerosis/ Parkinson's	☐	☐
Anemia	☐	☐	Swelling of Extremities	☐	☐
Diabetes	☐	☐	Artificial Joints	☐	☐
Hypoglycemia	☐	☐	Muscle Pain/ Fatigue	☐	☐
Cancer/Tumors/Growths	☐	☐	Light-headedness/ Dizziness	☐	☐
Blood disorders	☐	☐	Night Pain	☐	☐
HIV/AIDS	☐	☐	Night Sweats	☐	☐
Seizures	☐	☐	Are you pregnant?	☐	☐
Anxiety/ Panic Attacks	☐	☐	Bladder/ Bowel Incontinence	☐	☐
Depression	☐	☐	Other:		
Kidney Disease/ Stones	☐	☐	Height: Weight:		
Do you cough or choke when you eat or drink	☐	☐	Under 18 only: Immunizations current	☐	☐

Pain Assessment:
Rate your pain: (NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (UNBEARABLE)

Location of pain:_____

FALL RISK ASSESSMENT:	YES	NO
Have you fallen in the past 6 months?	☐	☐
Do you experience vertigo or dizziness?	☐	☐
Are you afraid of falling?	☐	☐
Have you recently felt unsteady? On your feet? Or in wheelchair?	☐	☐
Do you have vision problems?	☐	☐
Do you wear glasses?	☐	☐
Do you use sedatives that affect your arousal during the day?	☐	☐
Do you have a lower extremity disability that affects walking?	☐	☐

NUTRITIONAL SCREENING:	YES	NO
Diarrhea/ Nausea/ Vomiting	☐	☐
Unexplained weight loss? (> 5% in the last 30 days)	☐	☐
Loss of appetite/ aversion to food?	☐	☐
Decrease in food intake? (<50% for 3 days or more)	☐	☐
History of eating disorder?	☐	☐
Change in bowel habits?	☐	☐

List Current Medications: List Attached ☐

_____
_____
_____
_____
_____

Allergies: a. Medications: _____
b. Other Substances:_____
Surgeries and Dates: _____
X- Rays, MRI, CAT SCAN area of body & date: _____
(circle which applies)
What are your treatment goals? _____

If you need information regarding Advanced Directives, please contact the site Admission/ Office Assistant

PATIENT SIGNATURE: _____ **DATE: _____/_____/_____**

If patient is a minor include the relationship to patient: _____

This information will be used as a guide to your treatment plan. If you need any medical follow-up, please contact your physician.

For office use only

Patient has been identified as a fall risk: yes no (yes if patient answered yes to 3 or more fall risk questions above)
If yes, fall prevention program has been implemented: yes no
Patient has been identified as a nutrition risk: yes no Physician has been notified: yes no
Patient has been identified as requiring social service referral: yes no

PT Signature:_____ Date: _____/_____/_____
(therapist has reviewed the medical history form with patient)