Spectrum Physical Therapy & Athletic Training, LLC
Bergen County Physical Therapy

Raising the Standard for Optimal Care

Patient Demographic

Name: _____ **Date of Birth**: _____

Home Address: _____
Street City State Zip

Telephone: (_____) _____-_____(cell) (_____) _____-_____(home)

Email: _____ **Sex**: Male Female Decline to Specify

Referring Doctor: _____ **Prescription Present**: Yes No

*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.

Please complete if patient is under 18 years old.

Parent/Guardian Name: _____ Date of Birth: _____ Relationship: _____

Injury/Surgery

Injury/Condition: _____ **Approximate date of injury**: _____

Surgery? Yes No If Yes: Type of Surgery _____ Date of Surgery _____

Are you currently receiving home health care services? Yes No

Insurance Policy

Primary Insurance: _____ **Member ID**: _____

Insurance Policy Holder: _____ **Date of Birth**: _____

Relationship to policy holder: _____

Secondary Insurance: _____ **Member ID**: _____

Policy Insurance Holder: _____ **Date of Birth**: _____

Relationship to policy holder: _____

Please complete the following only if your injury is the result of a school, work, or auto accident.

Type of Accident: Worker's Comp Auto Accident School **Date of Accident**: _____ **State**: _____

Insurance Carrier: _____

Name of Employer/School: _____

Employer/School Address: _____
Street City State Zip

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

By signing below, I am authorizing Spectrum Physical Therapy & Athletic Training, LLC / Bergen County Physical Therapy 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**: _____

Health Insurance Benefits

*(The following **insurance** information is to be filled out by the office staff.)*

In Network Benefits / Out of Network Benefits

Patient Name:_____ Insurance Company:_____

Copay: $_____ Deductible: $_____of $_____met Visits allowed per year: _____

Coinsurance: _____% Out of Pocket: $_____ of $_____ met

Authorization required: Yes / No Prescription Required: Yes / No Referral Required: Yes / No

Copays are collected and due at the time of service. Patients will be responsible for copay as directed by Insurance representatives. If deductible applies, the patient will be responsible for the contracted rate until the deductible is met. The coinsurance applies once the deductible has been met. Deductibles and coinsurance will be balance billed.

As a courtesy, 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. Quoted benefits are not a guarantee of payment or coverage. 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 $150 for the initial evaluation and $100 per follow up visit.

Credit Card Information

Card Type: Visa MasterCard American Express Discover

_____	_____	_____	_____
Card Holder's Name	Credit Card Number	Expiration Date	CVV-Security Number

Cancellation & No-Show Policy

Please keep in mind when scheduling your appointments, we kindly ask that you notify our office at least 24 hours in advance if a cancellation or change must be made. If a cancellation is made with less than 24 hours' notice, Spectrum Physical Therapy / Bergen County PT, then reserves the right to charge a $50.00 cancellation fee.

We understand that your time is valuable, and in an effort to respect your time, that of our other patients, as well as the time of our doctors, our cancellation policy is strictly enforced. This time frame gives our staff the opportunity to fill the time slot that was set aside for your appointment, allowing other patients in need of appointments, to be seen by the doctors. By signing below, you agree that you understand the terms of Spectrum Physical Therapy's / Bergen County PT's Cancellation & No-Show Policy.

Video Surveillance Acknowledgement

To protect the safety of our patients, staff, and visitors at Spectrum Physical Therapy and Athletic Training, LLC / Bergen County Physical Therapy, the office and common areas of the clinic are 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 below, 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.

By signing below, I certify and acknowledge the above stated terms of Spectrum Physical Therapy and Athletic Training / Bergen County Physical Therapy.

Signature: _____ **Date**: _____

Payment Policy

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**. Spectrum PTAT requires notice 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.

Conditions of Admission to Spectrum Physical Therapy & Athletic Training, LLC. / Bergen County Physical Therapy 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") / Bergen County Physical Therapy, 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**: In the event that there is and 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 assure 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, HIPAA**: 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. **Bodily Fluid Exposure**: 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. **Overpayment**: 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.

By signing below, I certify to having read, reviewed, and agreed to the terms Spectrum Physical Therapy & Athletic Training LLC/ Bergen County Physical Therapy. I understand the contents of this form and agree to its terms and provisions.

Name: _____ **Signature**: _____ **Date**: _____

Medical History

Name: _____ Date of Birth: _____ Preferred Language: _____

Height: _____ Weight: _____ Are your Immunizations Current? (Under 18 only) Yes No

Emergency Contact Information:

Name: _____ Phone Number: _____ Relation: _____

Primary Care Physician Information:

Name: _____ Phone Number: _____

Religious/Cultural Needs: Yes No If Yes, please explain: _____

Special Learning Needs: Yes No If Yes, please explain: _____

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

Yes No High Blood Pressure
Yes No Chest Pain/Angina/Heart Attack
Yes No High Cholesterol
Yes No Pacemaker
Yes No Emphysema
Yes No Asthma
Yes No Shortness of breath
Yes No Fainting disorders
Yes No Hepatitis
Yes No Bleeding/Bruising
Yes No Anemia
Yes No Diabetes
Yes No Hypoglycemia
Yes No Cancer/Tumors/Growths
If yes, type_____
Yes No Blood disorders
Yes No HIV/AIDS
Yes No Seizures
Yes No Anxiety/Panic Attacks
Yes No Depression
Yes No Kidney Disease/Stones

Yes No Coughing or choking when you eat or drink
Yes No Spinal Cord Injury
Yes No Traumatic Brain Injury
Yes No Stroke
Yes No Fracture
If yes, When: _____ Area: _____
When: _____ Area: _____
Yes No Concussion
Yes No Osteoporosis
Yes No Multiple Sclerosis
Yes No Parkinson's
Yes No Swelling of extremities
Yes No Artificial Joints
If yes, please list: _____
Yes No Light Headedness/Dizziness
Yes No Night Pain
Yes No Night Sweats
Yes No Pregnant
Yes No Bladder/Bowel Incontinence

Other: _____

Fall Risk Assessment

Have you fallen in the past 6 months?	Yes	No
Do you experience vertigo or dizziness?	Yes	No
Are you afraid of falling?	Yes	No
Have you recently felt unsteady?	Yes	No
Do you have vision problems?	Yes	No
If yes, do you wear glasses?	Yes	No
Do you use sedatives that affect your arousal during the day?	Yes	No
Do you have a lower extremity disability that affects walking?	Yes	No

Nutritional Screening

Diarrea / Nausea/ Vomiting	Yes	No
Unexplained weight loss (>5% in the last 30 days)	Yes	No
Loss of Appetite/ Aversion to food?	Yes	No
Decrease in food intake (<50% for 3 or more days)	Yes	No
History of an eating disorder	Yes	No
Change in Bowel Habits?	Yes	No

Pain Assessment:

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

Location of pain: _____

Please list all current medications and dosage:

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Allergies:

Medications: _____

Other Substances: _____

Please list all surgeries and approximate dates:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Please list all MRI, CAT Scan, X-Rays, Imaging, etc., body part, and approximate date imaging was done:

_____ _____ _____ _____
_____ _____ _____ _____

What are your treatment goals?

_____
_____

Patient Signature: _____ **Date**: _____

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

For future use, please leave blank.

I have read and reviewed my medical history, and have made all necessary changes. By signing below, I an attesting that my medical history is current and correct as it appears on this form.

Signature: _____ Date: _____

----------*For office use only below this line*----------

PT Signature: _____ Date: _____

(Therapist has reviewed medical history form with patient)

Patient has been identified as a falls risk:		Yes	No (mark as yes if patient has 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	(mark as yes if patient has answered yes to 3 or more nutritional questions)
If yes, has physician been notified?	Yes	No	
Patient has been identified as requiring social service referral:	Yes	No	