

ORTHOPEDIC CARE PHYSICAL THERAPY CENTER, INC.

WELCOME! THANK YOU FOR CHOOSING OUR OFFICE. IN ORDER TO SERVE YOU PROPERLY, WE WILL NEED THE FOLLOWING INFORMATION. ALL INFORMATION WILL BE STRICTLY CONFIDENTIAL.

Patient Name: Last: _____ First: _____ **Please Circle one:**
MALE FEMALE

Address: _____
Street City State Zip Code

Phone #: Home _____ Work: _____ Cell: _____

SS# ____/____/____ **Are you on active duty in the military for the U.S.?** YES NO

Date of Birth: ____/____/____ **Marital Status:** S M W D **Date of Injury/ Surgery:** ____/____/____

How Injured: (Circle One) Job Related Automobile Other (Describe) _____

Patient's Employer: _____ **Occupation:** _____

Employer's Address: _____
Street City State Zip Code

Spouse's Name: _____ **Date of Birth** _____ **SS#:** _____

Spouse's Employer: _____ **Spouse's Work#:** _____

Party to notify in case of emergency: _____ **Relationship:** _____ **Phone #:** _____

Party responsible for patient if patient is a minor: _____ **SS#:** _____

INSURANCE INFORMATION

PRIMARY INSURANCE: Company: _____ Phone#: _____

ID or Claim #: _____ **Name of Insured** _____ **Insured's Date of Birth:** ____/____/____

WORKERS COMP or AUTO ACCIDENT please fill in the following:

Adjuster's/Rehab Nurse's Name: _____ **Phone #** _____

My signature below acknowledges that the foregoing information, to the best of my knowledge, is complete and correct. I authorize **ORTHOPEDIC CARE PT** to administer treatment as prescribed by my physician. My signature also authorizes assignment of benefits for the treatment rendered to **ORTHOPEDIC CARE PT** and the release of medical information pertaining to my treatment.

Signature

Date

ORTHOPEDIC CARE

Physical Therapy Center
23-00 Route 208
Fair Lawn, New Jersey 07410
(201) 796-1138

MEDICAL HISTORY

Name: _____

Date: ____/____/____

1. Do you have a history of heart disease ? ___Yes ___No

Yes No If yes, please specify _____

2. Are you presently taking any special medication?

Yes No If yes, please specify _____

3. Do you have a pacemaker?

Yes No If yes, please specify _____

4. Do you have any metal implants?

Yes No If yes, please specify _____

5. Do you have any known sensitivity to cold?

Yes No If yes, please specify _____

6. Is there any possibility of pregnancy?

Yes No If yes, please specify _____

ORTHOPEDIC CARE PHYSICAL THERAPY CENTER,INC
23-00 ROUTE 208
FAIR
LAWN, NJ 07410
201-796-1138

ASSIGNMENT OF INSURANCE BENEFITS

PATIENT'S NAME: _____

DATE OF ACCIDENT/ INJURY: _____

In consideration for services rendered to me or to be rendered to me in the future, I hereby authorize payment to the above-referenced provider of any and all insurance benefits to which I may otherwise be entitled for services rendered by the provider.

In the event that the provider's charges are outstanding, I hereby assign and authorize the provider to institute arbitration proceedings or other litigation for the purpose of the provider realizing payment for services rendered. It is also my intent that the provider receive payment directly from the insurance carrier, whether payment is issued prior to or as a result of arbitration proceedings or litigation.

This authorization and assignment or photocopy thereof shall authorize you to furnish all information you may have concerning my condition while under your observation or treatment.

SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____

DATE: _____

**ORTHOPEdic CARE
PHYSICAL THERAPY CENTER
23-00 ROUTE 208
FAIR LAWN, NEW JERSEY 07410**

BILLING POLICY

Patient Name: _____

As a service to you, Orthopedic Care Physical Therapy Center will submit your insurance claims.

A phone call will be made to your insurance company to verify the percentage your policy will cover for therapy charges. **THE INFORMATION OBTAINED FROM YOUR INSURANCE COMPANY IS ONLY A GUIDELINE TO INITIATE THE BILLING PROCESS; ORTHOPEDIC CARE PHYSICAL THERAPY CENTER WILL NOT BE HELD RESPONSIBLE FOR ITS ACCURACY.**

Managed Care Patients: **You are responsible to obtain referral forms. Co-pays must be paid at each visit.**

Non Managed Care Patients: **Co-insurance payments (your % due) must be paid weekly.** Any additional portion not paid by your insurance company including deductible and denied or non-covered services will be added to your bill upon notification from your insurance company.

IF YOU ARE A WORKER'S COMPENSATION CASE AND THE CLAIM IS DENIED, YOU ARE RESPONSIBLE FOR FULL PAYMENT. Payments can be made at our front reception desk or by mail; we accept cash, checks and credit cards. A finance charge of 1½% per month will be assessed to all delinquent accounts. If you have any questions regarding your bill, please contact the billing office.

Your insurance policy represents a contract between you and your insurance company. It is your responsibility to know the facts about your coverage. We cannot guarantee that your insurance company will pay all or part of your claim. If you are dissatisfied with their rejection of a claim or with the amount they paid, it is your responsibility to take the matter up directly with your insurance company. Naturally, we will be happy to work with you to provide any and all additional information necessary. **You will be held responsible for your account until it is paid in full.**

FEDERAL/STATE LAW REQUIRES THAT WE INFORM YOU THAT DELINQUENT ACCOUNTS MAY BE PROCESSED BY A COLLECTION AGENCY AT WHICH TIME THEY ARE SUBJECT TO INTEREST CHARGES, COLLECTION CHARGES, AND ALL COUNSEL AND COURT COSTS AS GOVERNED BY FEDERAL AND STATE REGULATIONS.

Your agreed payment for each visit will be _____. You will be balanced billed for your deductible, co-insurance and / or denied services.

Signature: _____

Date: _____

(IF PATIENT IS A MINOR - PARENT OR GUARDIAN PLEASE SIGN)

**ORTHOPEDIC CARE
PHYSICAL THERAPY CENTER, INC.
23-00 ROUTE 208 FAIR LAWN, NJ 07410**

PATIENT INFORMATION CONSENT FORM

I have read and fully understand Orthopedic Care P.T.'s Notice of Information Practices. I understand that Orthopedic Care P.T. may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Orthopedic Care P.T. will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Orthopedic Care P.T.'s Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Individuals are provided the right to request confidential communications or that communications to be made via alternative means, such as sending information to the individual's place of employment instead of their home.

- Home Telephone _____
 OK to leave a detailed message
 Leave a message with a callback number only
- Work Telephone _____
 OK to leave a detailed message
 Leave a message with a callback number only
- Cell Phone Number _____
 OK to leave a detailed message
 Leave a message with a callback number only

Signature

Print Name

Date