FORWARD MOTION
PHYSICAL THERAPY
Let us help you move forward.

Clifton Location
1111 Clifton Avenue, Clifton, NJ 07013
Phone: 973.400.3730 • Fax: 973.400.3731

Pequannock Location
167 Newark Pompton Tpke, Pequannock, NJ 07440
Phone: 973.987.3310 • Fax: 973.400.3731

PATIENT INFORMATION

Date:_____

First Name:_____ Last Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Date of Birth:_____ Height:_____ Weight:_____ Blood Pressure:_____

SS#:_____ Home Phone:_____ Cell Phone:_____

Sex: ☐ Male ☐ Female Age:_____ Email Address:_____

Emergency Contact Name:_____ Phone:_____

Employer's Name or School:_____ Phone:_____

How did you hear about us?: ☐ Family/Friend ☐ Doctor ☐ Workshop ☐ Internet

REFERRING PHYSICIAN

Name:_____

Phone#:_____

Address:_____

City:_____ State:_____ Zip:_____

PRIMARY CARE PHYSICIAN

Name:_____

Phone#:_____

Address:_____

City:_____ State:_____ Zip:_____

FINANCIAL RESPONSIBILITY (only if person financially responsible is different from patient above)

First Name:_____ Last Name:_____

Address:_____ City:_____ State:_____ Zip:_____

HEALTH INSURANCE INFORMATION (Primary)

Health Insurance Name:_____

ID#:_____ Group #:_____

Name of Insured:_____ Date of Birth:_____

Patient Relationship to Insured:_____

HEALTH INSURANCE INFORMATION (Secondary)

Health Insurance Name:_____

ID#:_____ Group #:_____

Name of Insured:_____ Date of Birth:_____

Patient Relationship to Insured:_____

REASON FOR PHYSICAL THERAPY

Body Part:_____ Date of Injury:_____

Surgery for this Injury: ☐ Y ☐ N Date of Surgery:_____

Was the injury a result of an accident? ☐ Auto Workers ☐ Comp ☐ Other

How did the pain start?

- ☐ Suddenly
- ☐ Gradually
- ☐ Lifting
- ☐ No apparent reason
- ☐ Pulling
- ☐ Injured at work
- ☐ Bending
- ☐ Other:_____

What activities make the pain worse?

- ☐ Exercise (during)
- ☐ Exercise (after)
- ☐ Sitting
- ☐ Walking
- ☐ Bending forward
- ☐ Bending backwards
- ☐ Coughing
- ☐ Sneezing

What reduces the pain?

- ☐ Lying down
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Anti-inflammatories
- ☐ Pain pills
- ☐ Injection for pain
- ☐ Muscle relaxants
- ☐ Nothing
- ☐ Other:_____

How long have you had this pain?

☐ Years ☐ Months ☐ Weeks

How long have you had similar pain?

☐ Years ☐ Months ☐ Weeks

Have you had any of these diagnostic tests?

- ☐ X-rays
- ☐ CT scan
- ☐ EMG/NCV MRI
- ☐ Arthrogram

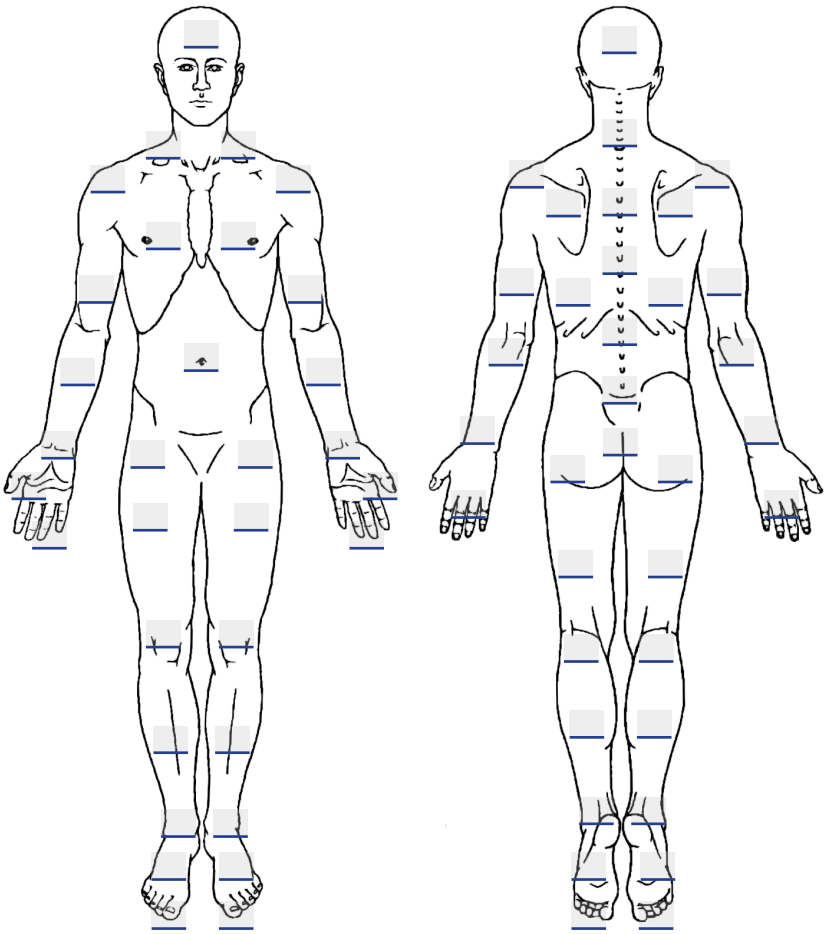
What medications are you currently taking?

_____

Do you have any of the following? (check all that apply)

- ☐ Allergies
- ☐ Arthritis-joint difficulties
- ☐ Cancer or tumors
- ☐ Change in bowel or bladder habits
- ☐ Change in stool color or rectal bleeding
- ☐ Changes in memory
- ☐ Diabetes
- ☐ Dizziness-blackouts
- ☐ Fever or chills
- ☐ Frequent cramping
- ☐ Frequent or easy bruising or bleeding
- ☐ Frequent urination
- ☐ Gout
- ☐ Heart disease/Stroke (CVA)
- ☐ High blood pressure
- ☐ Immunity disorders
- ☐ Increased thirst or hunger
- ☐ Indigestion or heartburn
- ☐ Irregular headaches
- ☐ Joint replacement
- ☐ Lung problems
- ☐ Nausea or vomiting
- ☐ Night sleep disturbance
- ☐ Seizures-nerve disorders
- ☐ Unusual fatigue-weakness
- ☐ Visual problems
- ☐ Are you pregnant?
- ☐ Do you awaken from pain?
- ☐ Do you have pain 24 hrs?
- ☐ Do you drink?
- ☐ Do you smoke?
- ☐ Other:_____

Patient Name:_____ Date:_____



PAIN/SYMPTOMS

On the Body Diagram to the left, indicate your region of pain using the symbols below:

(X) **Sharp**
(+) **Numb/Tingling**
(#) **Dull/Aching**
(B) **Burning**

Pain Level: 0>10

Patient Name: _____ **Date:** _____

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I, the undersigned do hereby agree and give consent for Forward Motion Physical Therapy, LLC (FMPT) to furnish medical care and treatment to (Patient) _____ that is considered necessary and proper in diagnosing or treating my his/her condition.

Notice of Privacy Practice
As per HIPPAA guidelines, I acknowledge that I have read and understand the NOTICE OF PRIVACY PRACTICE for FMPT and may be furnished with a copy upon my request.

Benefit Assignment
I hereby assign medical benefits to which I am entitled, including Medicare, private insurance, and third party payers to FMPT. A photocopy of this assignment is to be considered as valid as the original.

Financial Policy Statement
If any payment is made directly to me for services billed by FMPT, I recognize an obligation to promptly remit that amount along with any explanation of payment to FMPT. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including original charges, interest, collection agency fees, and attorney fees.

Billing and Benefits
It is the patient's responsibility to maintain all prescriptions, referrals, and authorizations as required by your insurance company. We will bill your insurance carrier as a courtesy to you. We have called your insurance carrier for estimated insurance benefits, and they are as follows:

_____

Your *estimated* financial responsibility is:_____

Estimated coverage information is provided as a courtesy to our patients and is not intended to release them from total responsibility of treatment. **Please be aware that is not a guarantee of benefits.** Actual plan benefits can only be determined upon receipt and processing of your claims (Federal Regulation Code 29 Section 2560.503-1)

I have read the above information and understand my responsibilities.

_____
Patient/Guardian Signature

_____ _____
Witness/Employee Signature **Date**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED & DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operation.

- TREATMENT means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would be sending medical information to the referring physician.
- PAYMENT means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill and/or chart notes for your visit to your insurance company for payment.
- HEALTH CARE OPERATIONS include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be sending charts to the physical therapy network for quality assurance review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders, reschedule appointments, or provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive and accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of July 20, 2009 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a copy of the revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complain

Please contact us for more information:
Forward Motion Physical Therapy
1111 Clifton Avenue Suite 101
Clifton, NJ 07013

For More Information about HIPAA or to file a complaint:
The US Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue SW
Washington, DC 20201

Medical Assignment of Benefits & Financial Policy. Please read this document in its entirety Financial Policy, Release of Information, Assignment of Benefits

- We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment. If you have any questions, please discuss them with us prior to beginning therapy.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to us. In other words, you agree to have your insurance company pay us directly. If your insurance company does not pay us within a reasonable time period, we will have to look to you for payment of the outstanding balance.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Your insurance company may send you payment, you are required to submit to us the endorsed check for deposit by our office for any & all payments made to you, by your insurance, for services rendered in our office. Payment is due immediately upon receipt. Any delay may result in late fees, and/or penalties.
- You are responsible for all copays, coinsurance, deductibles, and out of pocket expenses incurred.
- You must inform our office of all insurance changes and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges that are denied.
- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian for payment.
- All health plans are not the same and do not cover the same services. We will do our best to determine what services are covered by your insurance and let you know if there is a recommend treatment that is not a benefit of your insurance so that you may decide to proceed with the treatment or elect not to have the treatment performed. In the event your health plan determines a service to be "not covered" and we are unaware or you do not have authorization, you will be responsible for the complete charge.
- If you have a copay, you may either pay each time you come for your appointment or you may pay in advance to cover all visits for the week. Once the insurance company has begun to process our bills, if there is a balance due, we will send you a statement each month for the amount you owe - i.e. deductible, coinsurance, copay, until all claims have been processed.
- Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees, and court fees shall become your responsibility in addition to the balance due this office.
- I have read and understand the financial policy of Forward Motion Physical Therapy and 1 agree to be bound by its terms. I also understand that such terms may be amended from time to time by this office.
- I authorize the release of information necessary for treatment, payment & health care operations.
- I also authorize assignment of benefits for services rendered by Forward Motion Physical Therapy.

****There is a $25.00 service fee for all returned checks **A $75.00 fee will be charged for all "No Shows" & $25 Cancellations without a 3-hour notice before your appointment.**
****This fee is not reimbursable by insurance.**

Patient Information and Signature

I have read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information.
I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

Patient Name _____ **Signature** _____ **Date** _____

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Effective Immediately

CANCELLATION / NO - SHOW POLICY & FEES

NO SHOW FEE

$75 fee charge

For any no-show scheduled appointment.

CANCELLATION FEE

$25 fee charge

For any appointments cancelled

A minimum of 3 hours before you're scheduled Appointment time.

THANK YOU FOR YOUR COOPERATION!

Patient Name (Please Print)

Signature

Date

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New patients will be required to purchase their own THERABANDS.

There is a ONE time $5 flat fee of any THERABANDS needed to complete the patient's plan of care.

Due to COVID-19, patients must all have their own THERABANDS to minimize the risk since they cannot be properly disinfected by our staff.

Thank you for your cooperation and understanding.

_____
Patient Name (Please Print)

_____ _____
Signature Date

Paid:_____(employee initials)