Teaneck Orthopaedic Physical Therapy, LLC

1182 Teaneck Road, Suite 101
Teaneck, NJ 07666
Phone: 201-357-5421

Patient Demographic Information

Date: _____

Patient's Name: Last: _____ First: _____ Middle Initial: _____

Date of Birth: ___/___/___ Sex: ☐ Male ☐Female Gender Identity: _____

Home Address: _____

City: _____ State: _____ Zip _____

Email Address: _____ May we contact you through this email? ☐ Yes ☐No

Home Phone: _____ Cell: _____ May we contact you at these numbers? ☐ Yes ☐No

Current Employer: _____

Work Address: _____

City: _____ State: _____ Zip: _____

Work Phone #: _____

Primary Care Physician: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Referring Physician: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Medical Insurance Information

***NOTE**: Please submit your Personal ID and Insurance Card to the office for photocopying. Thank you!*

Primary Insurance: _____ Phone #: _____

Member ID: _____ Group #: _____

Are you the Subscriber or the Dependent? _____

Subscriber Name: _____ DOB of Subscriber: ____/____/____

Secondary Insurance: _____ Phone #: _____

Member ID: _____ Group #: _____

Are you the Subscriber or the Dependent? _____

Subscriber Name: _____ DOB of Subscriber: ____/____/____

How did you hear about us? _____

Name of the person who referred you to us and the relationship? _____

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Authorization to Release Information

ASSIGNMENT OF BENEFITS
I, or my dependent or legal guardian, hereby authorize, the assignment of insurance rights and benefits to Teaneck Orthopaedic Physical Therapy, LLC for the services rendered. I understand that I am solely responsible for all charges not paid by insurance, regardless of my insurance status. (**Our policy requires payments in full for all services rendered at the time of visit unless other arrangements have been made. You will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your payment**.)

All information on the registration sheet has been completed. I certify that the personal information that I have written in the registration is true and correct to the best of my knowledge and will be responsible for notifying the office of any changes in my status. A photocopy of this assignment shall be effective and valid as the original.

AUTHORIZATION TO RELEASE FORM
I hereby authorize Teaneck Orthopaedic Physical Therapy, LLC to release my medical insurance information to the third-party payer for insurance benefit verification and billing of claims. I also authorize this office to contact my primary care or referring physicians to obtain and discuss matters related to my treatment or any health-related issues.

INFORMED CONSENT FOR INITIAL ASSESSMENT, REASSESSMENT, PROGRESS ASSESSMENT, AND RENDERING OF TREATMENT
"Physical Therapy" is a specialty that aims to remediate impairments and promote functional mobility, functional activities of daily living, and quality of life, through examination, diagnosis, prognosis, and physical intervention such as manual therapy, therapeutic exercise, therapeutic activity, neuromuscular re-education, application of adhesive tapes, and therapeutic modalities (superficial moist heat, cold pack, unattended electrical stimulation, therapeutic ultrasound). These procedures will be explained and will not be conducted unless you authorize it.

I hereby, authorize the physical therapist or physical therapist assistant employed or contracted by Teaneck Orthopaedic Physical Therapy, LLC to conduct an initial evaluation, a re-evaluation, a re-assessment, and treatment of my body. The conduct of the assessment may include direct contact or palpation of torso, neck, limbs to assess muscle tone, tender points, skin mobility; testing of joint integrity; muscular strength; or testing of static or dynamic balance and gait; or testing of functional mobility abilities.

The response to the intervention varies from person-to-person; hence, it is not possible to accurately predict your response to a specific treatment modality, procedure or exercise protocol. Teaneck Orthopaedic Physical Therapy, LLC cannot guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is possibility that the treatment may result in further exacerbation of existing signs and symptoms.

You have the right to decline any part of the treatment at any time, before or during treatment session, should you feel any further discomfort or pain or have other unresolved concerns. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

I have read this consent and understand the risks involved and agree to fully cooperate and participate in physical therapy and comply with the established plan of care.

FINANCIAL ARRANGEMENT AND MEDICAL INSURANCE

We are committed to providing you with the best of care possible. As a courtesy, we will process the insurance claims to your insurance for payment, however, all charges are your responsibility for the services rendered.

Applicable payment for services rendered are due at the time of service such as co-pay and co-insurance. We accept cash, check or debit/credit card.

You are responsible for the rejection of insurance payments on the corresponding date of service as reflected on the explanation of benefits (EOB).

We will charge you $25.00 for unnotified broken appointments. Please notify us ahead of time, at least 24 hours beforehand.

Returned checks and balances older than 30 days on the last check received are subject to an additional collection fee and interest charge of 1.5% monthly (18% per annum).

Please sign below indicating you have read and understand the information contained in this document.

Patient Name: _____ (Print) Patient Signature: _____ (Sign) Date: _____

Witness' Name: _____ (Print) Witness' Signature: _____ (Sign) Date: _____

Teaneck Orthopaedic Physical Therapy, LLC
HIPAA Compliance Officer
Attn: Martin Malaluan, III
1182 Teaneck Road, Suite 101
Teaneck, NJ 07666
Phone: 201-357-5421

Notice of Patient Information Practices

THIS NOTICE DESCRIBES HOW MEDICAL AND PERSONAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS FORM CAREFULLY.

OUR LEGAL DUTY
Teaneck Orthopaedic Physical Therapy, LLC is required by law to protect the privacy of your personal and health information, provide notice about our information management practices, and follow the information protocols described below.

USES AND DISCLOSURES OF HEALTH INFORMATION
Teaneck Orthopaedic Physical Therapy, LLC uses your personal and health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and assess the quality of care we are proud to provide. We use your personal information to contact you to arrange an appointment with us and to properly bill your insurance carrier for the services we provided. In addition, we may, from time to time, disclose your health information without prior authorization for public health purposes, auditing, tracking, and research studies. In any other situation, Teaneck Orthopaedic Physical Therapy, LLC will obtain your written permission and authorization before disclosing your personal health information. If you provide us with written authorization to release your information for any reason, you may later revoke that authorization to cease future disclosures at any time. If and when any changes are made in our privacy and confidentiality policies, a new Notice of Information Practices will be posted in the same area for public view. You may request a copy of our Notice of Information practices at any time. Our HIPAA Compliance Officer is Martin Malaluan, III. He can be reached at the office by calling (201) 357-5421.

PATIENT'S INDIVIDUAL RIGHTS
You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct inaccurate or incomplete information in your records. You also have the right to request a list of instances where we disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes. You may request, in writing, that we not use or disclose your personal health information for treatment, payment, or administrative purposes except when specifically authorized by you, when required by law, or in an emergency. Teaneck Orthopaedic Physical Therapy, LLC will consider all such requests on a case-by-case basis. The company is not legally required to accept the requests.

CONCERNS AND COMPLAINTS
If you are concerned that Teaneck Orthopaedic Physical Therapy, LLC may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our HIPAA Compliance Officer, Martin Malaluan, III, at the office address and phone number listed above. You may also send a written complaint to the U.S. Department of Health and Human Services.

PRIVACY PRACTICE ACKNOWLEDGEMENT:
I have received the Notice of Privacy Practices and have been provided the opportunity to read it.

Patient Name: _____ Patient Signature: _____ Date: _____
(Print) (Sign)

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name _____ **Date** _____

1. Describe your symptoms _____

_____

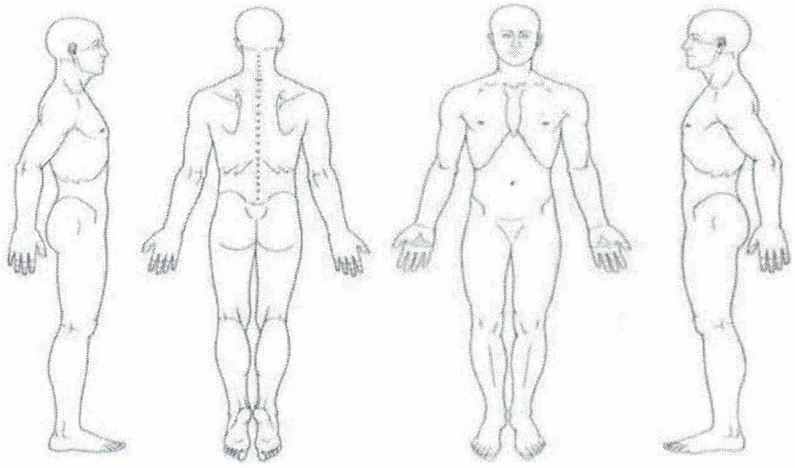
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

(1) Constantly (76-100% of the day)
(2) Frequently (51-75% of the day)
(3) Occasionally (26-50% of the day)
(4) Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

(1) Sharp (4) Shooting
(2) Dull ache (5) Burning
(3) Numb (6) Tingling

4. How are your symptoms changing?

(1) Getting Better
(2) Not Changing
(3) Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

(1) Not at all (2) A little bit (3) Moderately (4) Quite a bit (5) Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

(1) All of the time (2) Most of the time (3) Some of the time (4) A little of the time (5) None of the time

7. In general would you say your overall health right now is...

(1) Excellent (2) Very Good (3) Good (4) Fair (5) Poor

8. Who have you seen for your symptoms?

(1) No One
(2) Chiropractor
(3) Medical Doctor
(4) Physical Therapist
(5) Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

(1) Xrays *date:* _____ (3) CT Scan *date:* _____
(2) MRI *date:* _____ (4) Other *date:* _____

9. Have you had similar symptoms in the past? (1) Yes (2) No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

(1) This Office
(2) Chiropractor
(3) Medical Doctor
(4) Physical Therapist
(5) Other

10. What is your occupation?

_____

(1) Professional/Executive
(2) White Collar/Secretarial
(3) Tradesperson
(4) Laborer
(5) Homemaker
(6) FT Student
(7) Retired
(8) Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

(1) Full-time
(2) Part-time
(3) Self-employed
(4) Unemployed
(5) Off work
(6) Other

Patient Signature _____ **Date** _____

PATIENT INTAKE FORM (Page 2)

11. Do you consider this problem to be severe?
□ Yes □ Yes, at times □ No

12. What aggravates your problem?

_____

13. What concerns you the most about your problem; what does it prevent you from doing?

_____

14. What alleviates your problem?

_____

15. What is your: **Height**_____ **Weight** _____ **Age** _____ **Birth Date** _____

16. What type of exercise do you do?
□ Strenuous □ Moderate □ Light □ None

17. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

18 For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss	□	□ Visual Disturbances
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	□	□ Dizziness
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Asthma
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Chronic Sinusitis
□	□ Arthritis	□	□ Hepatitis	**For Females Only**	
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder	□	□ Birth Control Pills
□	□ Cancer	□	□ General Fatigue	□	□ Hormonal Replacement
□	□ Tumor	□	□ Muscular Incoordination	□	□ Pregnancy
□	□ Other:_____				

19. List all prescription medications you are currently taking:

_____

20. List all of the over-the-counter medications you are currently taking:

_____

21. List all surgical procedures you have had:

_____

22. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

23. What activities do you do outside of work?

_____

24. Have you ever been hospitalized? □ No □ Yes
if yes, why _____

25. Have you had significant past trauma? □ No □ Yes

26. Anything else pertinent to your visit today?_____

Patient Signature_____ ***Date:***_____