North Jersey Physical Therapy Associates, Inc. (NJPTA)

www.northjerseypt.com (Apr 2022)

Assignment of Benefits

I authorize payment of insurance benefits be made directly to North Jersey Physical Therapy Associates, Inc (NJPTA) for any services rendered to me and/or my dependents by NJPTA.

Authorized Representative

I hereby appoint NJPTA as my authorized representative with the power to (1) file medical claims with my health plan (2) file reconsiderations, appeals and grievances with my health plan (3) discuss or divulge any of my personal health information or that of my dependents with my health plan.

Authorization to Release Information/Consent to Use and Disclose Health Information

I understand that this practice maintains health records describing the health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care regarding myself or my dependents. I understand that this information will be used for the purposes of treatment, payment and healthcare operations. Treatment includes the disclosure of health information to other providers who have referred you for services or are involved in your care. Payment includes the disclosure of health information to your insurance company or its administrator so payment can be obtained for services rendered. Health Care Operations include utilization of your records to monitor quality of care given at this practice. I authorize the release of any medical or other information necessary for the purposes stated above.

Notice of Privacy Practices

I have a right to review or request a copy of the N*otice of Privacy Practices* that provides a more complete description of information uses and disclosures prior to signing this consent. A copy may be obtained in one of the NJPTA office locations or on their website. I have the right to object to the use of my health information for directory purposes. I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this organization is not required to agree to the restrictions requested. **I wish to have the following restrictions to the use or disclosure of my health information:**

_____

_____

Financial Responsibility

I understand deductible payments, co-pays, estimated co-insurance amounts, self-pay, late cancellation fees, no-show fees, and payments for supplies are expected to be paid at the front desk at the time of service. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my insurance carrier for any amount not covered by my insurer. I will promptly notify the organization of any changes in my health care coverage. **If I receive insurance checks, I will not wait for a statement and will forward these payments to NJPTA within 15 days of receipt from my insurance company. Failure to do will result in late fees at $20 per month.**

$60 Fee will be assessed for Late (Same Day) Cancellations and No-Shows

To maximize the benefit of your treatment, our physical therapy staff provides one-on-one care during treatment sessions reserved especially for you. Consistency in treatment is important to your rehabilitation outcome, and missing appointments will impede your progress. Make every effort to attend every scheduled visit according to the treatment plan recommended by your therapist and doctor. **If you cannot attend your scheduled appointment time, we ask that you notify us at least 24 hours prior to your appointment so we may accommodate other patients, and you can avoid the $60 fee.**

There is a $30 returned check fee.

Name of Patient (print)_____

Signature of Patient or Parent/Guardian:_____**Date:**_____

North Jersey Physical Therapy - Medical Questionnaire - Page 1 (Apr 2022)

Date: _____ Name: _____ Age: _____

Occupation: _____ Are you currently working? _____

How did you hear about our practice? _____

Referring physician (full name): _____

Primary Care Physician or other physician involved in your care:_____

Condition/Symptoms (reason you are here): _____
_____

Date of Onset: _____ Cause of condition: _____

Have you had previous episodes of this condition? _____ If yes, when? _____

Have you received physical therapy for this condition prior to today? _____ If yes, was it helpful? _____

What other treatments have you received for this condition? Were they helpful?
_____

Diagnostic tests for this condition? X-ray MRI CT scan EMG Other _____
Results of test(s): _____

Are you getting: better worse staying the same

How close to full normal function are you now? 0% 25% 50% 75% 100%

What are your goals for physical therapy? _____

Today my pain level is:	no pain - 0	1	2	3	4	5	6	7	8	9	10 - worst pain
Minimum pain level in past week:	no pain - 0	1	2	3	4	5	6	7	8	9	10 - worst pain
Maximum pain level in past week:	no pain - 0	1	2	3	4	5	6	7	8	9	10 - worst pain

What worsens the pain? _____

What decreases the pain? _____

Besides pain, do you have? Numbness Tingling Weakness Other _____

On the lines below, write the appropriate letter: “C” for current conditions, "P" for past conditions

____ Asthma	____ Cancer	____ Hypoglycemia	____ Seizure Disorder
____ AIDS	____ Cardiac Condition	____ Low Blood Pressure	____ Sleep Disorder
____ Angina	____ Chronic Infection	____ Lyme’s Disease	____ Thyroid Condition
____ Arthritis	____ Diabetes	____ Migraines	____ Tuberculosis
____ Bladder Disorder	____ Hepatitis	____ Polio	____ Other
____ Bowel Disorder	____ High Blood Pressure	____ Respiratory Condition	_____

Surgeries/Fractures (include dates/approximate dates and outcomes: _____
_____

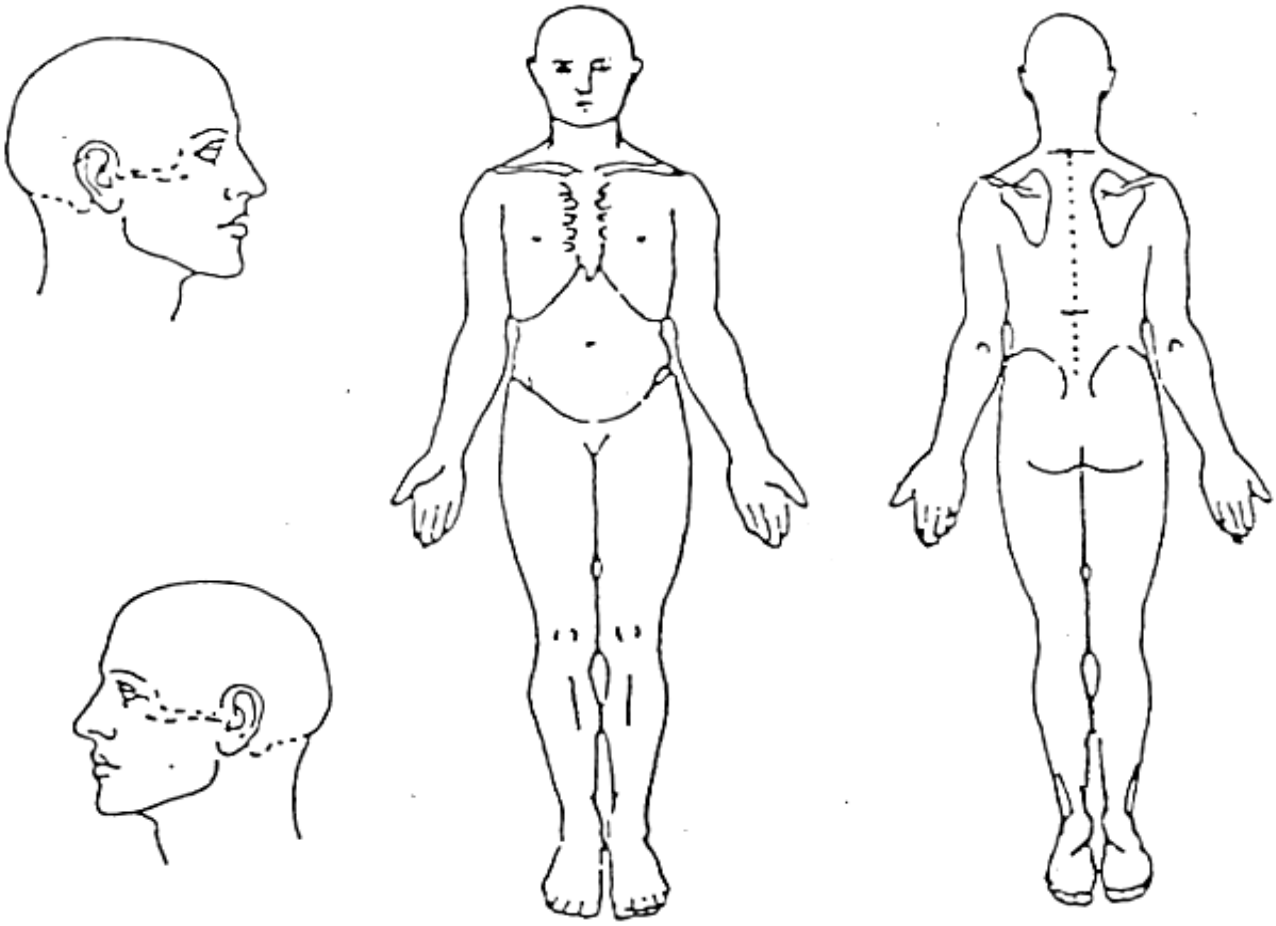
North Jersey Physical Therapy – Medical Questionnaire – Page 2
Body Chart (Apr 2022)

Name: _____ Date: _____

Please mark the figure below by using the following symbols to indicate where your pain is and what kind of pain you are having.

Feel free to write comments regarding your symptoms on this form.

Burning: xxxx **Stabbing: >>>>**
Aching/Throbbing: oooo **Numbness/Tingling: ///////**



North Jersey Physical Therapy – Medical Questionnaire – Page 3
Patient - Specific Functional Scale (Apr 2022)

Name: _____

List 3-5 activities you are having difficulty performing due to your condition.
See examples at the bottom of the page.

Rate each activity from 0 to 10 in the appropriate column next to the activity.
The lower the number the more difficulty you are having in performing the activity.

0 = UNABLE to perform the activity
10 = ABLE to perform activity at same level as before injury or problem

List 3-5 activities below that you have difficulty performing due to your condition:	**1st visit Evaluation**	**1st Progress Report**	**2nd Progress Report**	**3rd Progress Report**
Date →				
1. Rate →				
2. Rate →				
3. Rate →				
4. Rate →				
5. Rate →				
Average (Therapist will calculate.) →				

Activity Examples:

Prolonged sitting/standing	Bending over	Lifting and Carrying,
Pushing and Pulling	Reaching overhead	Looking up/down,
Turning head side to side	Walking (time/distance)	Running (time/distance)
Sleeping	Walking up/down steps	Reading
Driving	Kneeling,	Squatting,
Grasping,	Chewing,	Swallowing,
Yawning	Breathing	

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature: _____

Name: _____ Date: _____

Allergies: _____

_____

Medication List: List all medications you are currently taking with dosages and frequency. Please include all over-the-counter medication, prescription, vitamin/mineral/dietary (nutritional) supplements and herbals. Continue on the back if needed. You may provide us with a list of your own containing all the information below.

Medication	Dosage	Frequency	How Administered

Answer the following questions if you are a patient at risk for falling:

	Yes	No
Have you fallen within the last year? If yes, how many times? _____	☐	☐
Have any of these falls resulted in an injury within the last year?	☐	☐
Are you afraid of falling?	☐	☐
Have you recently felt unsteady on your feet?	☐	☐
Do you experience dizziness or vertigo?	☐	☐
Do you have vision problems that are not corrected by glasses?	☐	☐
Do you use sedatives that affect your level of alertness during the day?	☐	☐
Do you have memory/cognitive difficulties?	☐	☐
Do you have a lower extremity disability that affects walking?	☐	☐