



CHECK LIST OF DOCUMENTS

PLEASE SUBMIT THE FOLLOWING

(SOME DOCUMENT MAY BE SUBMITTED ONLY IF APPLICABLE)

- Doctor's Physical Therapy Prescription
- Primary Ins Card _____
- Secondary Ins Card _____
- X-Ray Report
- MRI Report
- EMG/NCV Report
- Medical Record from previous Physical Therapy Treatments

- Motor Vehicle Accident
- Worker's Compensation
- Accident Report
- Claim No. _____
- Lawyer's Name _____
- Phone No. _____
- Case Mgr. _____
- Phone No. _____
- Pre-cert _____

Patient's Name _____

Date _____



BERGENFIELD PHYSICAL THERAPY & PAIN MANAGEMENT

108 S. Washington Ave., Suite B, Bergenfield, NJ 07621 PHONE: 201-384-0200 FAX: 201-384-0030

PATIENT REGISTRATION

PLEASE PRINT CLEARLY / ENCIRCLE

Last Name: _____ First Name: _____ MI _____

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

Home Phone: _____ Cell Phone: _____ Date of Birth: _____

SS #: _____ Driver's License: _____

SEX: Male / Female

MARITAL STATUS: Married / Single / Separated/Widowed

STUDENT STATUS: Full time / Part time

EMPLOYER'S INFORMATION:

Employer's Name: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Work Phone: _____ STATUS: Full time/Part time unemployed/ Self Employed/ Retired

REFERRING LAWYER: (if applicable) _____ Phone: _____

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

PRIMARY INSURANCE INFORMATION:

Insurance Name: _____

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

Ins. Phone No. _____ Policy holder's Name: _____

Policy No. _____ Group No. _____

Annual Deductible: \$ _____ Co-pay: \$ _____ Capitated Plan: \$ _____

Percentage of Service: 50/50 60/40 70/30 80/20 90/10 100% Other: _____

Treatment Authorization From: _____ Authorized Number of Visits: _____

Authorization / Claim Number: _____ Adjuster: _____

SECONDARY INSURANCE INFORMATION: (if applicable)

Insurance Name: _____

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

Ins. Phone No. _____ Policy holder's Name: _____

Policy No. _____ Group No. _____

Annual Deductible: \$ _____ Co-pay: \$ _____ Capitated Plan: \$ _____

Percentage of Service: 50/50 60/40 70/30 80/20 90/10 100% Other: _____

Treatment Authorization From: _____ Authorized Number of Visits: _____

Authorization / Claim Number: _____ Adjuster: _____



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EMERGENCY CONTACT:

Spouse's Name: _____ Work Phone: _____ Cell #: _____

Nearest Relative not living with you: _____ Phone: _____

Nearest friend not living with you: _____ Phone: _____

Name of Land lord: _____ Phone : _____

Consent for treatment

I voluntarily consent to the rendering of care, including treatment and performance of therapeutic procedure. I understand that I am under the care and supervision of the attending Licensed Physical Therapist.

Authorization to release form

I hereby authorize the release of any information pertinent to my case to any insurance company, medical providers or lawyer involve in this case

I authorized Bergenfield Physical therapy to initiate complaint to Insurance Commissioner for any reason on my behalf.

Assignment of Benefits

I hereby assign direct payment to Bergenfield Physical therapy and Pain management for the services rendered under their direct supervision. I understand that I am financially responsible for any balance not covered by my insurance, regardless of my insurance status. All information on the registration sheet has been completed. I certify that this information is true and correct to the best of my knowledge and will be responsible in notifying your office on any changes in my status on the above information. A photocopy of this Assignment shall be considered as effective and valid as the original

Financial Arrangements and Medical Insurance

We are committed to providing you with the best possible care as a medical provider our relationship is with you, and not with your insurance company. We will process your claim for payment. While the filling of insurance claim is a courtesy that we extend to our patient, all charges are your responsibility from the date the services are rendered.

1. Applicable Payment for services is due at the time services are rendered, unless payment arrangements have been approved in advance by the billing department. We accept cash, checks and credit cards
2. You are responsible for rejected treatments dates and/or amount reflected in the Explanation of benefits given by your insurance company.
3. A charge of \$75 may also be made for broken appointments and cancelled appointments without 24 hours advance notice.
4. Returned checks and balances older than 30 days on the last check received are subject to additional collection fee and interest charge of 1.5 % monthly (18% per annum).

Patient Signature: _____ Date Signed: _____

Patient (if minor): _____ *Date signed:* _____

Privacy Practice Acknowledgement

I have received the Notice of privacy Practice and have been provided an opportunity to review it.

Name _____ Birth date: _____

Signature: _____ Date: _____



BERGENFIELD PHYSICAL THERAPY & PAIN MANAGEMENT

108 S Washington Ave. Ste B, Bergenfield, NJ, 07621 Phone:(201) 384-0200 Fax:(201) 384-0030

MEDICAL HISTORY SCREENING FORM

Patient Name: _____ Spoken Language: _____

Emergency Contact: _____ Telephone #: _____

Referring Physician: _____ Telephone #: _____

TO THE BEST OF YOUR KNOWLEDGE, DO YOU HAVE OR HAD ANY OF THE FOLLOWING:

- | | | | | | |
|--------------------------------------|-----|----|--------------------------------|-----|----|
| 1. High Blood Pressure | yes | no | 25. Thyroid Problems | yes | no |
| 2. Chest pains/ angina/ heart attack | yes | no | 26. Polio/ Muscle Disease | yes | no |
| 3. High Cholesterol | yes | no | 27. Seizures | yes | no |
| 4. Pacemaker | yes | no | 28. Chronic/ Migraine Headache | yes | no |
| 5. Shortness of Breath | yes | no | 29. TMJ Disorders | yes | no |
| 6. History of Smoking | yes | no | 30. Chills/ Fever Sweats | yes | no |
| 7. Lung Problems | yes | no | 31. Swelling of Extremities | yes | no |
| 8. Emphysema/ Asthma | yes | no | 32. Sleep Disorders | yes | no |
| 9. Bleeding/ Bruising | yes | no | 33. Depression | yes | no |
| 10. Anemia | yes | no | 34. Fibromyalgia | yes | no |
| 11. Diabetes | yes | no | 35. Chronic Fatigue Syndrome | yes | no |
| 12. Hypoglycemia | yes | no | 36. Lyme's Disease | yes | no |
| 13. Light headedness/ Dizziness | yes | no | 37. Cancer/ Tumors/ Growths | yes | no |
| 14. Blood Disorders | yes | no | 38. Are you Pregnant? | yes | no |
| 15. Concussion | yes | no | 39. Gynecological Disorders | yes | no |
| 16. Fainting Disorders | yes | no | 40. Bladder Incontinence | yes | no |
| 17. Anxiety/ Panic Attacks | yes | no | 41. Bowel Incontinence | yes | no |
| 18. Arthritis/ Joint Pain | yes | no | 42. Diarrhea/ Nausea/ Vomiting | yes | no |
| 19. Artificial Joints | yes | no | 43. Unexplained Weight Loss | yes | no |
| 20. Kidney Disease/ Stones | yes | no | 44. UNDER 18 y/o ONLY | | |
| 21. Hepatitis | yes | no | Immunization Current | yes | no |
| 22. Spinal Cord Injury | yes | no | | | |
| 23. Traumatic Brain Injury | yes | no | | | |
| 24. Fractures: | | | | | |

Date: _____ Area: _____

Date: _____ Area: _____

45. Rate your Pain **0 - 10**

0 **1** **2** **3** **4** **5** **6** **7** **8** **9** **10**
(NONE) (UNBEARABLE)

CURRENT MEDICATION: _____

ALLERGIES: A. To Medications: _____

B. To Substances: _____

SURGERY (S) Include dates: _____

X-RAYS, MRI, CAT SCAN (Include Area & dates)

WHAT ARE YOUR TREATMENT GOALS?

Patient Signature _____ **Date:** _____

Relationship if other than patient/Parent/Guardian if Minor _____

This information will help guide us to establish your treatment plan. If you need any medical follow-up, please contact your physician.

NOTICE OF PRIVACY PRACTICES



BERGENFIELD PHYSICAL THERAPY & PAIN MANAGEMENT

108 S Washington Ave. Ste B,
Bergenfield, NJ, 07621

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

This notice takes effect on _____ and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that law permits the changes.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use or disclose your medical information for payment purposes.

FOR HEALTH CARE OPERATIONS: We may use or disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

NOTICE OF PRIVACY PRACTICES

Victims of Abuse, Neglect, or Domestic Violence: We may disclose medical information to appropriate authorities if we reasonably believe that you are possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose health information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceeding, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

4. YOUR INDIVIDUAL RIGHTS

You Have the Right to:

1. Look at or get copies of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you \$ 1.00 for each page, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different location must be made in writing to the contact person listed at the end of this notice.
5. Request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the Privacy Officer at your office.

QUESTIONS AND COMPLAINS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a writing complain to the U.S. Department of Health and Human Services. We will provide you with the address to file your complain with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

NOTICE OF PRIVACY PRACTICES

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facilities' directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification: Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief: Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising: We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances: Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, and Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceeding: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grant jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a subject, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacement, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contacting or spreading a disease or condition.



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PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birth date _____

Signature _____

Date _____



Simple Agreement Form

Patient authorized the Doctor to deposit checks received on Patient's account when made out to the Patient.

Signature: _____

Date: _____



BERGENFIELD PHYSICAL THERAPY & PAIN MANAGEMENT

108 S Washington Ave. Ste B, Bergenfield, NJ, 07621 Phone:(201) 384-0200 Fax:(201) 384-0030

Date _____

Patient: _____

Employer: _____

Claim Group: _____

SS# / ID: _____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to:

**BERGENFIELD PHYSICAL THERAPY
& PAIN MANAGEMENT**
135 Bloomfield Ave. Suite C
Bloomfield, NJ 07003

or

if my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

**BERGENFIELD PHYSICAL THERAPY
& PAIN MANAGEMENT**
135 Bloomfield Ave. Suite C
Bloomfield, NJ 07003

for the professional or medical expenses benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charge over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorized the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorized doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at _____ this _____ day of _____, 20_____

Signature of Policyholder

Witness

Signature of Claimant, if other than Policyholder.



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ACCIDENT INFORMATION

MVA/PIP/WORKMANS COMP

Patient's Name: _____

Date of Accident: _____ Time: _____

Place of Accident: _____

Brief Description of Accident: _____

Where You The: (Circle one) Driver? Passenger? Pedestrian?

Did you go to the Hospital After the Accident? YES NO

Name of the Hospital and Address: _____

Name of attending Physician: _____

Claim N°: _____

Insurance Carrier & Address: _____

Case Manager: _____

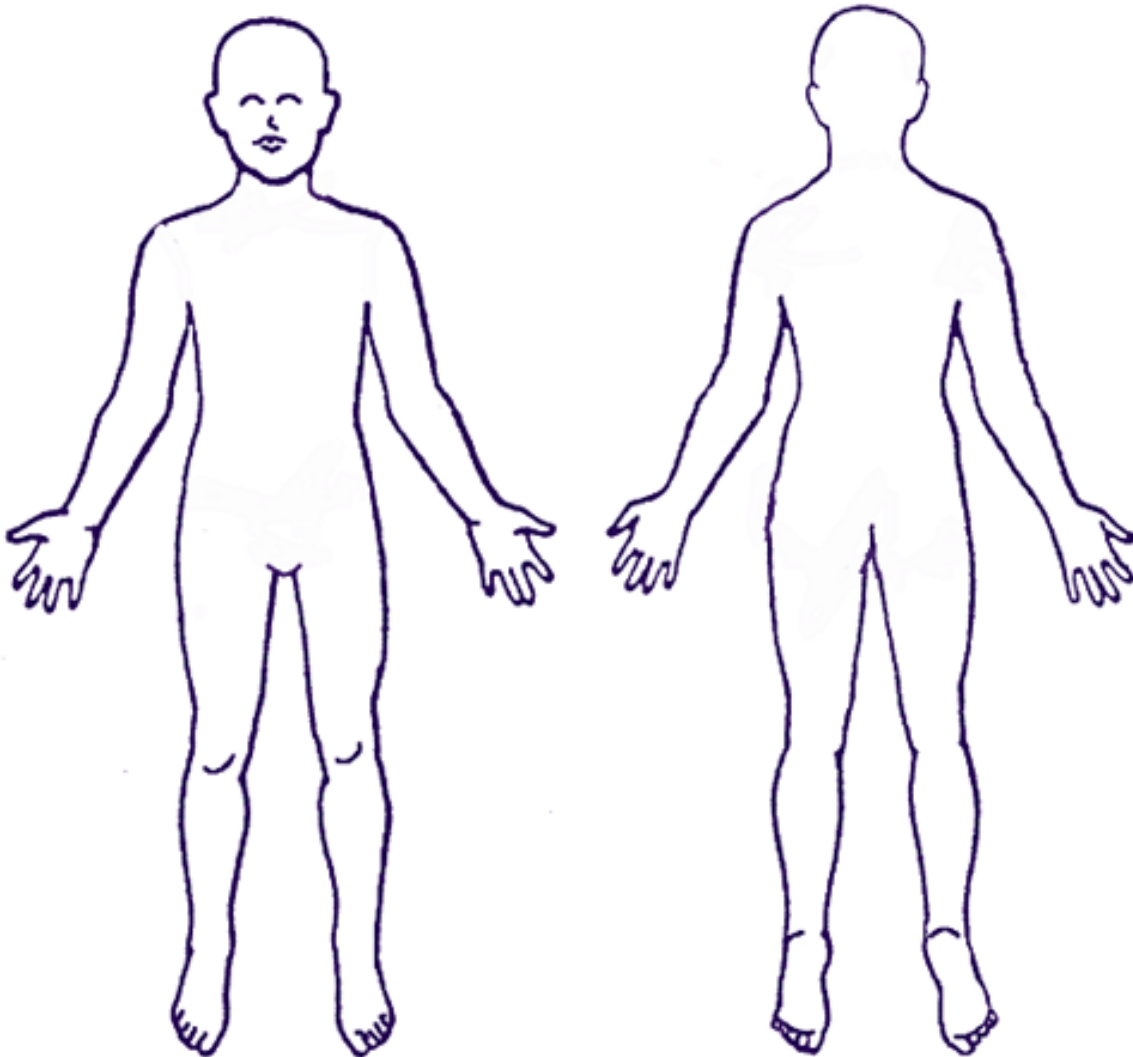
Tel N°: _____ Fax N°: _____

Do you have Private Health Insurance? YES NO

Name & Address: _____



BODY CHART



Please shade the area in which you feel most of your symptoms.

NAME: _____ DATE: _____