PATIENT INFORMATION

• Therapist you are seeing today: _____ • Appointment Date: _____

• PATIENT NAME _____

• PLEASE CHECK: ☐ Male ☐ Female • ARE YOU: ☐ Right ☐ Left Handed ☐ Ambidextrous

• MARITAL STATUS: ☐ M ☐ D ☐ S ☐ W ☐ P

• AGE _____ • BIRTHDATE_____ • HEIGHT ____ ft _____ in • WEIGHT _____ lbs

•OCCUPATION: _____
☐FT / ☐PT / ☐ Self-Employed / ☐Unemployed / ☐ Retired / ☐ Disabled / ☐FT Student / ☐PT Student

INJURY INFORMATION

• Date of injury or accident or onset of symptoms: _____

• Side of the body you are being seen for today (circle one): **LEFT** **RIGHT** **BILATERAL**

• ☐ Auto Accident? • ☐ Work Injury?

Describe your injury or the onset of your symptoms

Have you been seen for a previous injury or symptoms for this body part? Yes No☐ ☐
If yes, by whom: _____

TREATMENT

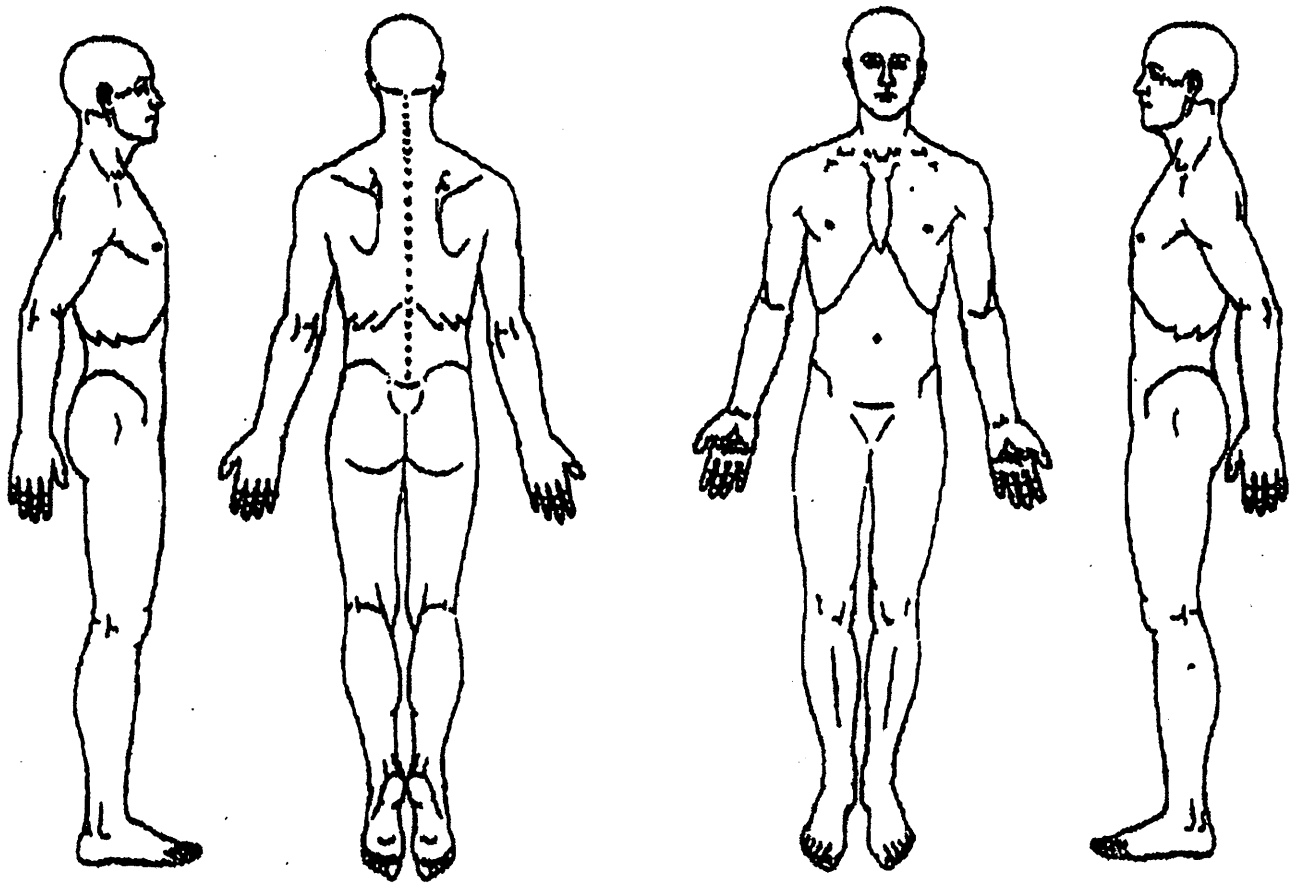
Seen in ER? When: _____ Where: _____
Treatments? ☐ Injection ☐ Physical Therapy ☐ NSAID / Pain Meds ☐ Brace
Tests/Scans Done? ☐ X-rays ☐MRI ☐CAT Scan ☐ Bone Scan ☐ Nerve Test (EMG/NCV)
Where? _____ Did you bring them with you today? ☐ ☐

PAIN ASSESSMENT

Please indicate the level of your pain for the injury listed above. Please circle the number below.

0 1 2 3 4 5 6 7 8 9 10

- Location of pain (place mark(s) where you have pain)



- Character of pain (circle all that apply)

SHARP ACHY DULL BURNING TINGLING ELECTRIC STABBING

- What activities or positions make the pain worse?: _____

PAST MEDICAL HISTORY ☐ None

Do you have any of the following medical problems? Please check all that apply:

☐ Anemia	☐ Heart Murmur	☐ Liver Disease/Hepatitis	☐ Phlebitis/Pulmonary Emboli/Blood clots
☐ Asthma	☐ High Blood Pressure	☐ Lupus/SLE	☐ Rheumatoid Arthritis
☐ Diabetes	☐ High Cholesterol	☐ Lyme's Disease	☐ Skin Rash/Psoriasis
☐ Emphysema/COPD	☐ Irregular Heartbeat	☐ Multiple Sclerosis	☐ Stroke/ TIA
☐ Gout	☐ Irritable Bowel	☐ Osteoarthritis	☐ Thyroid Disease
☐ Heart Attack /CAD	☐ Kidney Problems	☐ Osteoporosis	☐ Ulcers
☐ High Blood Pressure	☐ Epilepsy/ Seizures	☐ Infectious Disease	☐ Sleeping Problems/ Difficulties
☐ Cataracts	☐ Crohn's Disease	☐ Gallbladder Disease	☐ GERD
☐ Heart Disease	☐ High Lipids	☐ Hematuria	☐ Low Back Pain
☐ Chest pain/Angina	☐ Diverticulitis	☐ Duodenal Ulcer	☐ Pneumonia
☐ Stomach Ulcer	☐ Urinary Incontinence	☐ Ulcerative Colitis	☐ Herniated Disc/Cervical
☐ Scoliosis	☐ Neurological Disorder	☐ Parkinson's Disease	☐ Carpal Tunnel Syndrome
☐ Weakness	☐ Tuberculosis	☐ Hernia	☐ Prostate Enlargement/BPH
☐ Shortness of Breath/ Chest Pain		☐ Dizziness or Fainting	☐ Weight Loss/ Energy Loss
☐ Pacemaker/ Defibrillator		☐ Severe or Frequent Headaches	
☐ Any Pins or Metal Implants		☐ Joint Replacement	☐ Neck Injury/Surgery
☐ Shoulder Injury/Surgery		☐ Elbow Injury/Surgery	☐ Back Injury/Surgery
☐ Wrist/Hand Injury/Surgery		☐ Knee Injury/Surgery	☐ Leg/Ankle/Foot Injury/Surgery

☐ Cancer - Please tell us what type: _____

☐ Other (please list): _____

For female patients: Last menstrual period? _____ Problems? _____

PAST SURGICAL HISTORY ☐ None

Have you ever had surgery? Please check and give the dates to all that apply.

	DATE		DATE		DATE
☐ Appendix		☐ Bowel/Colon		☐ Breast Biopsy	
☐ Gallbladder		☐ Gynecologic		☐ Heart Surgery	
☐ Hernia Repair		☐ Tonsils			
☐ Cosmetic Surgery_____ (please list type)		☐Other_____ (please list body part)			
☐ ORTHOPAEDIC _____					
(please list all) _____					
_____					

MEDICATIONS ☐ None

Do you take any of the following medications on a regular basis? Please check all that apply.

☐ Anti-Inflammatory ☐ Aspirin ☐ Birth Control Pills ☐ Coumadin ☐ Tylenol

Please list any prescription medications you are currently taking:

ALLERGIES ☐ None

Do you have any **allergies** to any medications? (Please list all that apply & your reaction)

Do you have an allergy to Latex? ☐ Yes ☐ No

FAMILY HISTORY ☐ None

Do your parents, siblings, or grandparents have any of the following? Please check all that apply & indicate which family member:

☐ Cancer ☐ High Blood Pressure ☐ Rheumatoid Arthritis
☐ Diabetes ☐ Osteoporosis ☐ Stroke
☐ Heart Disease

Do you have any deceased family members? Please check all that apply and indicate cause of death.

☐ Mother ☐ Father ☐ Sibling ☐Grandparent

Cause: _____ _____ _____ _____

SOCIAL HISTORY

Please check all that apply:

Do you smoke tobacco/Vape? Currently: ☐ Every day? ☐ Some days? ☐ Never smoked? ☐ Former Smoker?
How much per day/week? _____ Years smoked? _____ When quit? _____

Do you drink alcohol? ☐ No ☐ Yes If Yes, how often? ___Daily ____Other ____/ week

Have you ever been treated for chemical dependence? ☐ No ☐ Yes

Are you pregnant? No ☐ Yes ☐ # of Children _____

Hobbies _____

Musical Instrument _____

Sports _____

Are you currently being treated for Osteoporosis or have you had any testing for Osteoporosis?

☐ NO ☐ YES If **YES**, please list the treatment and/or testing you have received and when:

_____

Are you HIV Positive? ☐ NO ☐ YES

Have you received a COVID vaccination? ☐ Yes ☐ No

PROFESSIONAL ORTHOPEDIC ASSOCIATES PHYSICAL THERAPY

Informed Consent for Physical Therapy and Occupational Therapy Services

The purpose of Physical and Occupational Therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis, and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

Response to therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. POAPT does not guarantee that treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the therapy treatment may result in aggravation of existing symptoms and may cause pain or injury. It is very important to communicate with your treating therapist throughout the treatment.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your therapist about the treatment they have planned based on your individual history, therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand the risks involved in Physical/Occupational Therapy and agree to fully cooperate, participate in all therapy procedures, and comply with the established plan of care. I authorize the release of my medical information to appropriate third parties.

_____	_____	_____
Patient Name	Patient Signature	Date

PROFESSIONAL ORTHOPEDIC ASSOCIATES PHYSICAL THERAPY

HIPAA PRIVACY POLICY NOTICE

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Disclose health information in order to conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment both directly and indirectly.
- Disclose your health information in order to receive payment services we provide to you.
- Disclose your health information for normal healthcare operations such as quality assessments and physician certifications.

PATIENT RIGHTS REGARDING MEDICAL INFORMATION

The Right to Inspect and Copy Your Information: You may review and copy your medical records and information.

The Right to Amend: You may ask that we amend your health information if you believe that your information is incomplete or incorrect.

The Right to Request Restrictions: You may request a restriction or limitation on how and what health information we disclose regarding you for treatment, payment of health operations or to your family or care-givers.

The Right to Confidential Communications: You may request that we communicate with you about medical matters in a certain format or a specific location.

The Right to Receive a Copy of this Notice: You may request and receive a copy of this notice (or our current notice) at any time by contacting this organization.

_____ _____

Print Patient Name **Relationship to Patient**

_____ _____

Signature **Date**

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION
PROFESSIONAL ORTHOPAEDIC ASSOCIATES, P.A.

DATE OF REQUEST _____

Patient Name _____ **Date of Birth** _____

Address _____

****As required by the Privacy Regulations, Professional Orthopaedic Associates, P.A. may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.****

I, _____**, give permission for Professional Orthopaedic Associates, P.A. and any of its employees to release any or all of my Patient Health Information to the following relatives, friends, or acquaintances:**

_____

_____

I, _____**, give permission to the practitioner/facility listed below to release any or all of my Patient Health information to Professional Orthopaedic Associates, P.A. as part of my medical care.**

_____

_____

I, _____**. give permission for Professional Orthopaedic Associates, P.A. and any of its employees to leave information related to any or all of my care at the following number:**

_____ **Home** **Cell** **Work**
(please indicate what kind of number you have listed)

Patient information to be disclosed : <u>All</u> **For the specific purpose of :** <u>Any</u>

Effective date for authorization _____/_____/_____.

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and is no longer protected by these regulations.

I understand that the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits.

I understand I have the right to:

1. **Revoke this authorization by sending a written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.**
2. **Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, as a result of this authorization.**
3. **Inspect a copy of Patient Health Information being used or disclosed under federal law.**
4. **Refuse to sign this authorization.**
5. **Receive a copy of this authorization.**
6. **Restrict what is disclosed with this authorization.**

_____ _____
Signature of Patient or Patient's authorized representative **Date**

_____ _____
Authorized signature of Professional Orthopaedic Associates staff **Date**

Patients with no insurance: Payment is expected at the time of service. A specific payment plan acceptable to both you and the office may be arranged.

Patients with insurance: Deductibles and all co-insurances are expected at the time of service. Your co-insurance is not covered by your insurance and is not always an exact percentage. You will be sent a statement showing both your account balance and your anticipated responsibility. If a patient's balance remains unpaid for more than 90 days, the patient's account may be turned over to an attorney/collection agency for collections. If your account is sent to collections, you will be responsible for all collection fees generated.

INSURANCE POLICY

We extend to our patients the courtesy of allowing you to assign your insurance benefits directly to our office. This policy may reduce your out-of-pocket expense.

Please note the following:

1. **The privilege of insurance assignment begins when your insurance is qualified and the insurance forms received. Until that time you must pay for all services rendered.**
2. **All deductibles must be made prior to submitting your insurance claims.**
3. **Since we do not own your insurance policy, we are limited in our efforts to collect from your insurance company. We expect that you act on your own behalf with your insurance carrier. Frequent calls on the status of your claim often help speed up this process.**
4. **Due to the recent changes in our status with most insurance companies, it will be your responsibility to turn over to our office any checks and related explanations of benefits that your insurance company issues to you for services rendered with Professional Orthopaedic Associates in a timely manner.**
5. **It is our goal of this office to provide you with the finest quality of care available. If you have any questions regarding your healthcare or any of our office policies, please do not hesitate to let us know.**
6. **If it becomes necessary to utilize a collection agency due to nonpayment of your bill, you will be responsible for all fees charged by that agency as well as your balance.**

Please sign below:

I have reviewed these office policies and accept my responsibility as detailed above.

Print Name: _____

Signature: _____ **Date:** _____

I authorize my insurance company to make payments for my unpaid balance directly to: Professional Orthopaedic Associates

I hereby authorize the release of information to and from my insurance company, attorney, school, pharmacy or any other entity involved as it is related to my care and treatment.

Print Name: _____

Signature: _____ **Date:** _____

I hereby authorize my motor vehicle insurance carrier to release information to Professional Orthopaedic Associates regarding the PIP benefits that have been paid to date on my claim.

Print Name: _____

Signature: _____ **Date:** _____

We welcome your referrals and look forward to a Doctor-Patient relationship.

LEGAL ASSIGNMENT OF BENEFITS & DESIGNATION OF AUTHORIZED REPRESENTATIVE

I, _____, represent that I have valid and in-force insurance and/or employee health care benefits coverage, and hereby assign and convey directly to Professional Orthopaedic Associates and it's physicians (the "provider(s)"), as my designed Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from the provider(s), regardless of the provider's managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefits payments. I hereby authorize the provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to the provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from the provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the provider(s), to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, chose in action, or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s) under any applicable insurance policies, employee benefits plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I received from the provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including but not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by the provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, to bring suit by the provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____

Signature of Insurance/Guardian Date

_____

Print Name of Insured/Guardian

ASSIGNMENT OF BENEFITS/APPOINTMENT OF ATTORNEYS

I hereby assign all rights and benefits due me from my insurance carrier to Professional Orthopaedic Associates ("POA") and authorize and empower POA to appeal a determination by a carrier to deny, reduce or terminate my benefits including, but not limited to, the filing of a lawsuit or fee arbitration. Furthermore, I authorize and direct my insurance carrier to pay the proceeds of any benefits due me directly to POA. A copy of this can be considered as an original for insurance purposes. ____ *(initials)*

I acknowledge and understand that I am responsible for all of the charges for all of the services rendered to me or any member of my family. Although I have requested the doctor to bill my insurance company on my behalf, I clearly understand that it is still my responsibility to make sure the bill is paid within a reasonable amount of time. If for any reason any portion of the bill is not paid by my insurance carrier, I further agree to make arrangements for prompt payment of the bill. ____ *(initials)*

If I receive any payment from an insurance carrier relating to services rendered, I agree that I will hold such payment in trust for POA and I agree to send any such payment to POA within one week after I receive same. In the event my account is turned over to an attorney for collection, I agree to pay a legal and collection fee equal to 33 1/3% of the outstanding balance, plus court costs. ____ *(initials)*

I understand that should I not turn over the proceeds, an action for collection may be filed against me in which I agree to be responsible for payment of any court costs and attorney fees involved in efforts to collect the entire fee billed by the doctor, not just what has been paid to me by my insurance carrier. ____ *(initials)*

I agree that if POA treats me for any problem that is involved in litigation or involves a claim for personal injuries, I will immediately notify the Billing Department for my POA provider. At the time any settlement funds are disbursed or received, I promise to pay any and all of my provider's and POA's bills. ____ *(initials)*

I understand that my provider and POA may each bill for services rendered independently. I authorize this office to submit their bills to any insurance company with which I (or my spouse) have an insurance policy or any company against which I may proceed for medical expense benefits. ____ *(initials)*

In the event that the doctor elects to bring a lawsuit or petition for arbitration against the insurance carrier, I assign my rights, title and interest under any section of any insurance policy under which I am entitled to proceed for benefits. This assignment shall allow an attorney of their choosing to bring suit or submit to arbitration their claim for any unpaid bills for treatment rendered. My provider and POA may designate such attorney beginning thirty-one (31) days after any bill for services rendered becomes due. I agree to fully cooperate with them in the collection of any benefits from the insurance carrier including full cooperation with the chosen attorney. ____ *(initials)*

In the event this assignment is held invalid for any reason, I hereby authorize POA to appoint an attorney of its choice to represent me directly against an insurer from which I may collect any & all benefits and to bring a claim in a forum of the attorney's choice. This appointment is intended to enable the attorney to collect the bills of POA and this appointment does not authorize the selected attorney to represent me in any third-party action. Further, this appointment will not conflict with any other attorney who currently represents me. ____ *(initials)*

By consenting to having a law firm of POA's choosing represent me, I understand that in such lawsuits my confidentiality may not be protected and personal information may be revealed. I authorize my provider and POA to release any and all information concerning my injury or illness and its treatment to the attorney designated by the assignee or third person that are involved in the action to collect benefits. ____ *(initials)*
I have read, understand and agree to the above. ____ *(initials)*

_____ _____
Patient Name – please print Date

_____
Patient's Signature or Signature of Parent/Legal Guardian

PROFESSIONAL ORTHOPAEDIC ASSOCIATES

Authorization of Designated Representative to Appeal a Determination

Date: _____

Patient name: _____

Insured ID #: _____

I hereby authorize Professional Orthopaedic Associates, as my designated representative, to appeal to my insurance company, _____, on my behalf, in the
(please print name of insurance company here)

determination of services rendered by _____, and, as part of the appeal, I hereby
(doctor you are seeing today)

authorize _____ to disclose and furnish to my
(please print name of insurance company here)

designated representative, Professional Orthopaedic Associates, the following information:

All medical and financial information contained in my insurance file. I understand this information is privileged and confidential.

Patient Name: _____
(please print)

Legal Guardian's name: _____
(please print)

Signature of Patient or Legal Guardian: _____ Date: _____

_____
Signature of Professional Orthopaedic Associates Representative

POAPT
Physical Therapy

In the event that this account needs to be placed with an attorney or a collection agency because of an unpaid balance remaining on my account, I hereby agree to promise to pay interest of 1.5% per month of the outstanding balance (to be calculated starting from my last date of service). In addition, I also agree and promise to pay a collection fee of $100.00 or 40% of the total balance due, whichever is greater, upon placement with an attorney or collection agency due to an unpaid balance remaining on my account.

_____

Signature

_____

Printed Name

776 Shrewsbury Avenue. Suite 101 • Tinton Falls. NJ 07724
Phone: (732) 741-0665 • Fax: (732) 741-0668