CONFIDENTIAL NEW PATIENT QUESTIONNAIRE

1. LAST NAME: ______________________ FIRST NAME: ______________________ M: ________
2. ADDRESS: ______________________
3. CITY: ______________________ 4. STATE: ____________ 5. ZIP: ____________
6. HOME: (_____) ____________ 7. WORK: (_____) ____________ 8. CELL: (_____) ____________
9. AGE: _____ 10. DATE OF BIRTH: _____/_____/_____ 11. SEX: ☐ M ☐ F 12. SOC. SEC.# ______-_____-______
13. MARITAL STATUS: ☐ S ☐ M ☐ D ☐ W 14. SPOUSE'S NAME: ______________________
15. EMERGENCY CONTACT: ______________________ 16. TELEPHONE: (_____) ____________
17. REFERRED BY: ______________________
18. PRIMARY CARE PHYSICIAN: ______________________
ADDRESS: ______________________ TELEPHONE: (___)
19. EMAIL: ______________________
20. EMPLOYER NAME: ______________________
ADDRESS ______________________
CITY ______________________ STATE ____________ ZIP ____________
21. BUSINESS PHONE # (_____) ____________ 22. FAX # (_____)

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1. INSURED'S NAME ______________________ 2. INSURED'S DOB: _____/_____/_____
3. PATIENT'S RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ ____________
4. NAME OF INSURANCE CO. ______________________ 5. POLICY # ____________

***** SECONDARY INSURANCE (IF APPLICABLE) *****

1. INSURED'S NAME ______________________ 2. INSURED'S DOB: _____/_____/_____
3. PATIENT'S RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ ____________
4. NAME OF INSURANCE CO. ______________________ 5. POLICY # ____________
6. IS THE COORDINATION OF BENEFITS HANDELED FOR THIS YEAR ☐ NO ☐ YES

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1. INSURANCE TYPE: ☐ AUTO ☐ WORK ☐ LIEN ☐ ____________
2. PATIENT'S RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ ____________
3. NAME OF THE INSURED PERSON: ______________________ 4. INSURED DATE OF BIRTH: _____/_____/_____
5. DATE OF INJURY ____________ 6. DESCRIBE HOW INJURY OCCURED? ______________________
7. STATE IN WHICH ACCIDENT OCCURRED? ______________________
8. NAME OF INS. CO. ______________________ 9. INS. PHONE (_____) ____________
10. POLICY # ______________________ 11. CLAIM # ____________
12. DID YOU REPORT INJURY? ☐ NO ☐ YES IF YES, TO WHOM? ____________
13. WAS THE PIP APPLICATION SEND BACK TO THE INSURANCE COMPANY ☐ NO ☐ YES
14. WERE YOU WORKING AT THE TIME OF THE ACCIDENT? ☐ NO ☐ YES
15. NAMES OF OTHER DOCTORS SEEN FOR THIS INJURY ______________________
16. IF AUTO INJURY, WERE YOU? ☐ DRIVER ☐ PASSENGER ☐ PEDESTRIAN ☐ ____________
17. # OF PEOPLE IN YOUR VEHICLE? ____ 18. WORE SEAT BELT? ☐ NO ☐ YES 19. DID AIRBAG INFLATE ☐ NO ☐ YES
20. NAME OF ATTORNEY ______________________
ATTORNEY ADDRESS: ______________________
ATTORNEY TELEPHONE: (_____) ____________ ATTORNEY FAX: (_____) ____________

Confidential Patient Questionnaire

Name: ______________________________ **Date:** ______________

Major Complaint(s): ____

____

CHECK YOUR PRESENT AND PAST SYMPTOMS

Present	Past	Symptom	Present	Past	Symptom
☐	☐	Neck Pain	☐	☐	Excessive Thirst
☐	☐	Middle Back Pan	☐	☐	Chronic Cough
☐	☐	Low Back Pain	☐	☐	Sinus Problems
☐	☐	Headache	☐	☐	Chronic Fatigue
☐	☐	Dizziness	☐	☐	Painful Urination
☐	☐	Convulsions	☐	☐	Frequent Urination
☐	☐	Fainting, Visual Problems, Nausea	☐	☐	Difficulty with Bladder/Bowels
☐	☐	Shoulder Pain	☐	☐	Stomach Pain
☐	☐	Pain in Shoulder, Arms, Elbows	☐	☐	Difficult Swallowing
☐	☐	Pain in Hands	☐	☐	Depression
☐	☐	Pain in Upper Leg	☐	☐	High Blood Pressure
☐	☐	Pain in lower Leg	☐	☐	Angina
☐	☐	Pain in Ankle/Foot	☐	☐	Heart Attack
☐	☐	Swelling/Stiffness in Joints	☐	☐	Stroke
☐	☐	Jaw Pain	☐	☐	Asthma
☐	☐	Ringing in Ears	☐	☐	Cancer
☐	☐	Rapid Heart Beat	☐	☐	Emphysema
☐	☐	Chest Pain	☐	☐	Arthritis
☐	☐	Loss of Appetite	☐	☐	Diabetes
			☐	☐	Ulcers

Please describe your *current* pain: __ Sharp __Dull __ Aches __Sore __Weak __ Throbbing
__Shooting __Constricting __Burning __Tingling

Was your problem from a: __Car Accident __Work Related Injury __Started Gradually __Slip and Fall __Other

Describe how the problem began: ____

____

____

What treatment have you received for this condition: __Family Doctor __Chiropractic __ Physical Therapy
__Medical Specialist __Surgery __Injections __X-Ray __MRI Other______________

Have you ever had this problem before? __ Yes __No

What makes the problem better? __Nothing __ Lying Down __Walking __Sitting Other______________

What makes the problem worse? __Nothing __ Lying Down __Walking __Sitting Other______________

Are you currently working? __Yes __No
If yes, do you: __Sit more then 50% of the day __Light Manual Labor __Heavy Manual Labor

Does Your Problem Affect Your Daily Activities? __ No __Mild __Moderate __Significant Resretictions
Describe: ____

____

Do you Smoke? __No __Yes __Packs per Day

Do you Drink Alcohol? __No __Socially __Habitually

Patient or Legal Guardian Signature ______________________________

Date __________

Confidential Patient Questionairre page 2

Are you Pregnant? __No __Yes Date of Onset of Last Menstrual Period ______________

Are you Currently Taking Medication? ___No __Yes Please List all Medicaltions ______________

____

____

Do you have Any Allergies to Drugs or Other Products? __No __Yes
Describe: ______________

FAMILY HISTORY

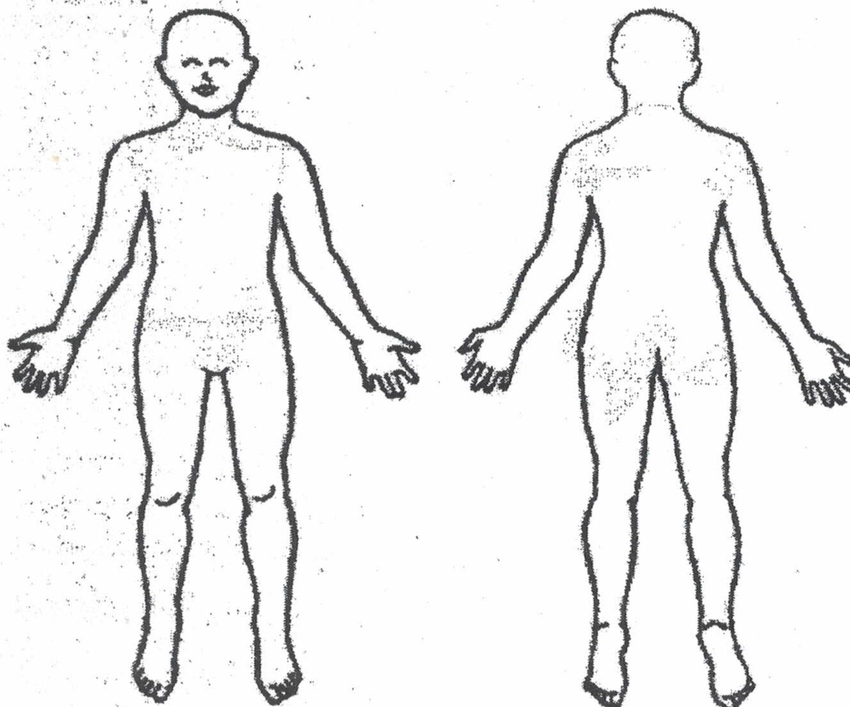
	Diabetes	Heart	Blood Pressure	Kidney	Cancer	Stroke	Other	
Mother	☐	☐	☐	☐	☐	☐	☐	______
Father	☐	☐	☐	☐	☐	☐	☐	______
Brother	☐	☐	☐	☐	☐	☐	☐	______
Sister	☐	☐	☐	☐	☐	☐	☐	______
Grandmother	☐	☐	☐	☐	☐	☐	☐	______
Grandfather	☐	☐	☐	☐	☐	☐	☐	______

Current Work Status:

- ☐ I Have Not Missed Any Days of Work
- ☐ I Have Missed ___ Days of Work
- ☐ I Have Been Put on Light Duty at Work
- ☐ I Have Had to Change my Job as a Result of my Condition

PAIN / SYMPTOM PICTURE

Please mark with an "X" where you have any symptoms



HEIGHT:
WEIGHT:

Patient or Legal Guardian Signature (X) ______________
Date: ______________

Patient Financial Policy

Thank you for choosing our office as your healthcare provider. We are committed to making your treatment successful. You are required to read and sign the following office financial policy prior to the commencement of any treatment.

Your insurance plan is an agreement between you and your insurance carrier. We are not party to that contract. You are responsible to know your policy. In the event that we do accept assignment of benefits, we require a credit card with authorization, which we will hold, in the event of non-payment otherwise. Your balance will become your responsibility if denied by your carrier for any reason. You reserve the right to appeal the reimbursement for services or lack of with your carrier pursuant to your health care insurance contract.

Please be aware that some and perhaps all services which we provide may be considered uncovered services, and therefore considered not medically necessary under the Medicare program and other insurance carriers.

You hereby authorize insurance payment directly to our office. Should payment be sent to you, it is your responsibility to return the check to our office, within seven (7) days of receipt. Failure to do so will result in civil collection proceedings wherein you agree to pay our reasonable attorney's fees and costs for collection as well as potential criminal liability for theft and conversion of funds. You further assign your rights to benefits under your contract of insurance or other third party payment **B&M Rehab LLC.** and its employees, agents and/or contractors, all benefits payable to you under you insurance policies and health benefits plans.

You hereby further provide to **B&M Rehab LLC** with a limited, irrevocable power of attorney to endorse any checks or other negotiable instruments made payable to you individually or jointly to you and to **B&M Rehab LLC.** This power expressly authorizes third parties including but not limited to commercial banking institutions to honor our endorsement on your behalf under this power of attorney and to accept deposit or cashing of any such negotiable instrument. This limited power of attorney shall be immediately effective and shall be durable in that it shall remain in full effect through any disability of the principal granting this power of attorney.

If your insurance plan requires a referral prior to the commencement of treatment, it is your responsibility to have one prior to the commencement of examination or treatment.

Our office plans an extensive portion of time to spend with you on each visit. Canceling or "no showing" causes a loss of this time, which could have been used to see other patients. We ask that you make every effort to keep your scheduled appointment. We reserve the right to charge you for the missed visit. This will not be covered by any insurance company. We ask that you please be considerate and help us to serve you better by keeping scheduled appointments.

THIS FINANCIAL AGREEMENT IS A VALID CONTRACT BETWEEN THE PATIENT AND HEALTH CARE PROVIDER. I CERTIFY THAT I HAVE READ THE ABOVE INFORMATION, OR THAT THE INFORMATION HAS BEEN READ OR TRANSLATED TO ME, AND THAT I UNDERSTAND MY RIGHTS AND OBLIGATIONS AS A PATIENT UNDER THIS AGREEMENT.

____
Patient Name, (Printed)

____
Witness:

____
Signature

____
Date

B&M of BERGEN
PHYSICAL THERAPY

2 Arnot Street, Suite 3, Lodi, NJ 07644 Tel. No. 973-472-7465 Fax No. 973-472-7466

Med Myra Mangcoy, PT, DPT

Physical Therapy INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of physical therapy treatments on me (or on the patient named below, for whom I am legally responsible) by the doctor of physical therapy named above and/or other licensed doctors of physical therapy who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of physical therapy named above, including those working in the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the therapist named above and/or with other office of clinic personnel the nature and purpose of physical therapy and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of physical therapy there are some risks to treatment, including, but not limited to, fractures, disc injuries, or strokes, dislocations, falls, dizziness, headaches, burns with modalities and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the therapist to exercise judgment during the course of the procedure which the therapist feels at the time, based upon the facts then known, and is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT PRINT NAME: ______________________ DATE: ______________

PATIENT SIGNATURE: ______________________

(Or Patient Representative) (Indicate relationship if signing for patient)

______________________ ______________________

B&M of BERGEN
PHYSICAL THERAPY
2 Arnot Street, Suite 3, Lodi, NJ 07644 Tel. No. 973-472-7465 Fax No. 973-472-7466

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

____
Patient Signature

____
Date

Appointment Cancellation/No-Show Policy

Thank you for trusting us for your physical therapy care. When you book your appointment with Rehabilitation Institute of North Jersey, we set enough time to provide you with the highest quality of care. Should you need to cancel or reschedule your appointment, please contact our office as soon as possible and no later than 24 hours prior to scheduled appointment. This gives us enough time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

>Effective immediately, any patient who fails to show, or cancels/reschedules an appointment and has not contacted our office with at least 24 hr. notice, will be considered a NO SHOW and charged a $50 fee.

>Should a NO SHOW occur 3 times, the patient may be discharged from the physical therapy.

>THE FEE IS CHARGED TO THE PATIENT, NOT THE INSURANCE COMPANY, AND IS DUE AT THE TIME OF THE PATIENT'S NEXT OFFICE VISIT.

2 Arnot Street, Suite 3, Lodi, NJ, 07644 tel: 973-472-7465 fax: 973-472-7566

We understand there may be times when an unforeseen emergency happens and you may not be able to keep you scheduled appointment. If you should experience extenuating circumstances, please contact the office as soon as possible. You may contact us 24 hours a day, 7 days a week at 973-472-7465. Should it be after regular hours of Monday through Thursday, or a weekend, you may leave a message. Messages left at the office is acceptable.

- **I have read and understand the Appointment Cancellation/No Show Policy and agree to its terms.**

______________________________ Signature

______________________ Date

______________________________ Print Name

B&M of BERGEN
PHYSICAL THERAPY

2 Arnot Street, Suite 3, Lodi, NJ 07644 Tel. No. 973-472-7465 Fax No. 973-472-7466

Authorization for the Release of Patient Records & Information

To: ______________________________
(Doctor or Hospital)

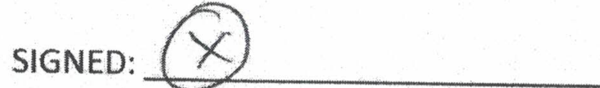
I, ______________________________, born on ____________________
(Name of Patient) (Date of Birth)

do hereby consent ______________________ to release any, and all records
(Doctor or Hospital)

in your possession for ____________________ including X-rays and reports,
(DOS)

concerning the undersigned to **B&M of Bergen Physical Therapy.**

DATE: ____________________

SIGNED: 

Relationship: ____________

Assignment of Benefits Form

Assignment and Release:

I, the undersigned, irrevocably assign to **B&M of Bergen Physical Therapy**, all my rights and benefits under any insurance contracts for payment for services rendered to me by **B&M Rehab LLC.** I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by **B&M Rehab LLC**, to be released to **B&M Rehab LLC.** I irrevocably authorize **B&M Rehab LLC.** to file insurance claims to my behalf for services rendered to me. I understand that all claims which are unpaid or denied by my insurance company become my financial responsibility. I further understand that all balances over 90 days are subject to a 1.5% compound monthly interest rate (18% APR). I irrevocably direct all such payments go directly to **B&M Rehab LLC.** I irrevocably authorize **B&M Rehab LLC.** to act in my behalf and report any suspected violations of proper claims practices to the proper regulatory authorities. This assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect.

______________________________ ______________

Responsible Party Signature Date

Patient's Medicare/Medigap Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **B&M Rehab LLC**, for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent any information needed to determine the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. I request that payment of the "other health insurance" benefits be made to me or on my behalf to **B&M Rehab LLC.** I permit a copy of this authorization to be used in place of the original. This authorization is in force until it is either canceled or changed by me.

______________________________ ______________

Patient Signature Date

DISCLOSURE OF INSURANCE PARTICIPATION

STATUS AND FEES

The laws of the State of New Jersey and New Jersey Department of Health and New Jersey Department of Banking & Insurance requires that a health care professional inform patients of the health care plans in which the professional participates in and the facilities with which the professional is affiliated with. In compliance with these laws, the undersigned patient is hereby notified, in writing, that:

Health Plans Our Practice Participates With:

Name:	Address:
Medicare, Amerihealth of NJ	2 Arnot St Suite 3
Horizon BlueCross BlueShield	Lodi, NJ 07644
United Healthcare, Cigna	

Facilities Our Practice Is Associated With and Addresses:

Name:	Address:
B&M Rehab LLC	2 Arnot St. Suite 3 Lodi, NJ, 07644

If the patient's health plan is not listed above, the physician and/or facilities providing services do not participate with the patient's health plan. In order to proceed with any health care services, the patient hereby acknowledges and agrees:

Licensed Assistant Healthcare Staff:

The following licensed healthcare professionals may perform assistant services on the patient based upon the treatment plan and needs of the patient:

Name:	**Address & Phone Number:**
______________________	______________________
N/A	______________________
______________________	______________________
______________________	______________________

Anesthesia, Radiology, Laboratory, Pathology Services:

The following outside service providers may be contracted to perform services on the patient based upon the treatment plan and needs of the patient:

Name:	**Address & Phone Number:**
______________________	______________________
N/A	______________________
______________________	______________________
______________________	______________________

The patient is hereby notified and understands that these assistants, anesthesia, radiology, laboratory and/or pathology services may not participate with the patient's health insurance plan and may be "out-of-network" providers subject to the following disclosures. Patient should inquire with each provider to determine their participation status and/or contact the patient's health plan or administrator for further consultation on cost associated with these services.

Mandatory Disclosure:

1) I understand that the health care professional that I am seeking healthcare services from is "out-of-network" with and does not participate with my health insurance plan;

Out-of-Network Patients		**In-Network Patients**
Patient Initials: _______	[or]	N/A: ______

2) I understand that the amount or estimated amount the health care professional will bill me or the covered person for the services is available upon request;

Out-of-Network Patients		**In-Network Patients**
Patient Initials: _______	[or]	N/A: ______

3) I understand that I may request from the provider and estimated charge for the services proposed and the Current Procedural Terminology (CPT) codes associated with that service, and the health care professional shall disclose to me, the patient, in writing, the amount or estimated amount that the health care professional will bill the covered person for the service, and the CPT codes associated with that service, absent unforeseen medical circumstances that may arise when the care service is provided;

Out-of-Network Patients		**In-Network Patients**
Patient Initials: _______	[or]	N/A: ______

4) I understand that I will have a financial responsibility applicable to health care services provided by an out-of-network professional, in excess of my in-network copayment, deductible, or coinsurance, and that I may be responsible for any costs in excess of those allowed by my health benefits plan.

Out-of-Network Patients		**In-Network Patients**
Patient Initials:_______	[or]	N/A:______

5) I have been advised that I should contact my health insurance plan or administrator for further consultation on the costs.

Out-of-Network Patients		**In-Network Patients**
Patient Initials:_______	[or]	N/A:______

The health care provider and patient both acknowledge and agree that receipt or acknowledgement by patient of these disclosures shall not wave or otherwise affect any protection under existing statues or regulations regarding in-network health benefits plan coverage available to the patient under the law.

The health care provider further acknowledges and agrees that, if, between the time these disclosures are made to the patient and the time the health care services takes place, the network status of any of the health care professional changes as it relates to the patient's health benefits plan, the professional shall notify the patient promptly.

Acknowledgement of Receipt of Disclosures- OUT-OF-NETWORK PATIENTS

I, the undersigned patient, acknowledge the receipt of this disclosure form from my health care provider, and have read it and understand the contents. I have discussed my option to obtain treatment with other health care providers, services providers, or at alternative health care facilities that may participate with my health plan and I waive the right to do so and wish to obtain my treatment at this office with full notice of these disclosures and potential cost sharing consequences. I certify that I am at least 18 years of age, competent, not under the influence of any drug, alcohol, or other substance that would impair my ability to understand these disclosures, am not being coerced to sign this disclosure, and do so upon my own free will.

By: ______________________________ Date: __________

Print Name: ______________________________

Acknowledgement of Receipt of Disclosures- IN-NETWORK PATIENTS

I , the undersigned patient, acknowledge the receipt of this disclosure form from my health care provider, and have read it and understand the contents. I understand that currently my out of pocket expenses will be limited to those described in my insurance policy and the contractual obligations between the health care provider and my insurance carrier. The health care provider further acknowledges and agrees that, if, between the place, the network status of any of the health care professionals' changes as it relates to the patients' health benefits plan, the professional shall notify the patient promptly. I certify that I am at least 18 years of age, competent, not under the influence of any drug, alcohol, or other substance that would impair my ability to understand these disclosures, am not being coerced to sign this disclosure, and do so upon my own free will.

By: ______________________________ Date: __________

Print Name: ______________________________

LIMITED POWER OF ATTORNEY TO HEALTH CARE PROVIDER

Date: ______________________________
Patient Name: ______________________________
Insurance Co: ______________________________

LIMITED POWER OF ATTORNEY:

I, ______________________________ [patient name] hereby appoint my health care provider, **B&M of Bergen Physical Therapy**, 2 Arnot St. Suite 3 Lodi, New Jersey 07644 as my attorney-in-fact with power to transact any business at all in my name as though I myself were acting limited to the following: endorse any checks received by me from the above named insurance company for services rendered in this office and depositing the check in my attorney-in-fact's business account for which my attorney-in-fact shall have full access to said funds as payment for services rendered with no further authorization or approval by me.
I hereby ratify and confirm all that my attorney(s)-in-fact shall lawfully do, or cause to be done, by virtue of this power of attorney. This Power of Attorney can be revoked by me by sending written notice of such revocation by certified mail, return receipt requested, to my attorney(s)-in-fact. This Limited Power of Attorney shall become immediately effective upon my signature and shall be affected by my physical or mental disability of incapacity or by uncertainty as to whether I am dead or alive, and it may be accepted and relied upon by anyone to whom it is presented until such person (1) receives written notice of revocation by me or a guardian (or similar fiduciary) of my estate; or (2) has actual knowledge of my death.

____
Patient or Guardian Signature   Date

Printed Name: ______________________________

Address: ______________________________

____

WITNESS:
I attest that the Patient or Guardian named above signed and dated this document in my presence and in the presence of the other witness. I hereby attest that, to the best of my knowledge and belief, the Patient or Guardian is of sound mind and free or duress and undue influence. I am not the Patient or Guardian's Attorney-In-Fact and I am an adult.

By: ______________________________
Name: ______________________________
Address: ______________________________
____