# Advance Spine and Pain Physical Therapy, LLC

225 East State St. Suite 12, Trenton NJ 08608
Tel: (609) 695-8100 Fax: (609) 695-8110 www.asappt.com


## Patient Intake Form

**Name:** _____ ☐ **Male** ☐ **Female**

**Address:** _____

**City, State, Zip:** _____

**Cell #:** _____

**Email Address:** _____ ☐**Married** ☐**Single**

**DOB:** _____

Primary Care Physician: _____ Phone #: _____

Emergency Contact: _____ Phone #: _____

**Was this injury a result of a work or auto accident**? ☐Yes ☐No

**Do you have a lawyer**? (Y/N)____ Name: _____ Phone # _____

Address: _____

**How did you hear about us**? (circle one) **Agency** **Friend** **Doctor-Referral** **Lawyer-Referral** **Online**

Name of referral (Agency/Friend/Dr/Lawyer or Website) _____

**Primary Insurance Information -** *Please complete ONLY if different than patient information.*
**Insurance Company:** _____ **ID#** _____
**Group #** _____
**Subscriber's Name:** _____ **DOB**: _____ **Sex**: _____
**Relation**: _____

**Additional Insurance Information -** *Please complete ONLY if it is different from patient information.*
**Insurance Company:** _____ **ID#** _____
**Group #** _____
**Subscriber's Name:** _____ **DOB**: _____ **Sex**: _____
**Relation**: _____

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**Past Medical History**

Name:_____ Date: _____ Date of Birth: _____

*Feel free to attach any additional documentation*

Past Medical History: _____
_____
_____

Past Surgical History: _____
_____
_____

Medications (please include vitamins/supplements): _____
_____
_____

Allergies (include medicines/latex):_____
_____
_____

Please check any of the following if you have had them currently or in the past:

[ ] Diabetes
[ ] Osteoporosis
[ ] Heart disease
[ ] Asthma
[ ] Epilepsy/Seizures
[ ] Night Sweats
[ ] Stroke
[ ] Cancer
[ ] Blood clot
[ ] Hepatitis
[ ] Bleeding tendency
[ ] Sudden unexplained weight changes
[ ] Pacemaker
[ ] Metal Implants
[ ] High Blood Pressure
[ ] HIV/AIDS
[ ] Pneumonia

Patient Signature: _____

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## Patient Consent

Name of Patient:_____

Your healthcare at Advance Spine and Pain Physical Therapy, LLC will consist of physical therapy. We will work together with you to diagnose and treat you. You will have a therapist responsible for your care. Evaluations, daily notes and a medical history intake form will become part of your medical record. You will be informed of alternatives to treatment or return to your referring physician if PT is not appropriate for you. The benefits of physical therapy are relief of pain and increase in function. Risks, although rare, include increase of pain, decrease in function, joint injury, rash, scratches/bruises, burns, fracture/dislocation, heart attack, pulmonary embolism, concussion and rarely death. If there is any part of this form that is unclear, you may ask questions about it. I hereby request and consent to medical treatment to be given to me by Advance Spine and Pain Physical Therapy, LLC.

Our fees are time based or service based fees. Charges may vary from one treatment session to the next based on medical necessity. It is important for you to know you are responsible for co-payments, co-insurances and/or deductibles. If you are on Medicare, be advised that Medicare only pays 80% of a covered claim. You are responsible for the 20%. Our office staff will be contacting your insurance carrier to verify eligibility. Depending on your coverage, we may be collecting money at the time services are rendered or you may receive a bill from us.

### Insurance Signature on File Authorization

I request that payment of authorized insurance (ie. Medicare, Aetna, etc.) benefits be made on my behalf to Advance Spine and Pain Physical Therapy, LLC, 225 East State St. Suite 12, Trenton, NJ 08608 for services furnished to me by the provider. Otherwise, I agree to pay all fees in accordance to the services provided to me. I authorize any holder of medical information about me to release to my lawyer/doctor and/or the insurance company/Centers for Medicare & Medicaid Services and its agents any information needed to secure the payment of these benefits or the benefits payable for related services and authorize the use of this signature on my insurance submission. I agree I know my own insurance coverage. I am responsible for charges denied by my insurance carrier.

Patient's Signature:_____ Date: _____

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## HIPAA Confidentiality of Patient Health Information Statement

I consent to the use or disclosure of my protected health information by Advance Spine and Pain Physical Therapy, LLC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Advance Spine and Pain Physical Therapy in accordance with the privacy provisions under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). My agreement shall survive until I am no longer a patient or until I revoke this agreement. I may revoke my consent at any time by written notice. (Your revocation will be effective when we receive it, but it will not apply to any uses/disclosures which occurred before that time).

I understand that diagnosis or treatment of me by Advance Spine and Pain Physical Therapy, LLC may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Advance Spine and Pain Physical Therapy, LLC is not required to agree to the restrictions that I may request. However, if Advance Spine and Pain Physical Therapy, LLC agrees to a restriction that I request, the restriction is binding on Advance Spine and Pain Physical Therapy, LLC. I have the right to revoke this consent, in writing, at any time, except to the extent Advance Spine and Pain Physical Therapy, LLC has taken action in reliance to this consent.

My "Protected Health Information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Advance Spine and Pain Physical Therapy, LLC's Notice to Privacy Practices prior to signing this document. I understand that signing is voluntary. Advance Spine and Pain Physical Therapy, LLC's Notice to Privacy Practices has been provided to me. The Notice to Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Advance Spine and Pain Physical Therapy, LLC. The Notice of Privacy Practices also describes my rights and duties of Advance Spine and Pain Physical Therapy, LLC with respect to my protected health information.

Advance Spine and Pain Physical Therapy, LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

| _____ | _____ | _____ |
|---|---|---|
| Signature | Name | Date |

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## Policies Form

Please note it is YOUR responsibility to understand your insurance benefits and not our responsibility to explain it to you. It is our responsibility according to the State of New Jersey to collect all fees due to our office including copays, deductibles and coinsurances. Those with Medicare are responsible for 20% of their healthcare costs. Please make sure you are knowledgeable about your specific health coverage.

All copays will be required before initiation of your appointment.

If for any reason, you owe a copay, coinsurance, deductible or other fee to our office and are invoiced this amount, you will be given 3 weeks to respond to that invoice notification. If you need to be put on a payment plan, please contact our office and do not ignore the invoice. Unpaid invoices will go to collections. In this event, you be responsible for your initial invoice and associated collections fees.

Due to the high number of individuals waiting for appointments at our center, we ask all patients to call and cancel an appointment they cannot make at least 24 hours before the scheduled appointment. Failure to do so will result in a no-show fee of $10. For multiple no-show, cancels or tardiness, we reserve the right to discontinue therapy.

Patients will receive an automated SMS, automated phone message and email reminders of appointments or other services. Please let us know at the front desk if you choose not to receive notifications.

Studies show patients who are involved in their physical therapy plan achieve better results. Not all patients are interested in making these decisions. We would like to know where you stand. Please circle the following that best describe your preference:

- I prefer to make the treatment decisions on my own.
- I prefer to share the treatment decisions with the therapist.
- I prefer to leave the decisions to the therapist.

I acknowledge the above set forth policies of Advance Spine and Pain Physical Therapy and agree to abide by these guidelines.

_____ _____
Patient Name Date

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## Medicare Questionnaire

Patient's Name: _____ Medicare #:_____

Legislation makes Medicare the secondary payor under certain circumstances. The following questions are designed to recognize those circumstances. This form will be retained in your folder for Medicare auditing purposes.

Do you have traditional Medicare ( ) or Medicare HMO ( )?

| Questions | Yes | No |
|---|---|---|
| Was your illness/injury due to a WORK RELATED ACCIDENT/CONDITION and is it being covered by a WORKERS COMPENSATION plan or the FEDERAL BLACK LUNG PROGRAM? | | |
| Was your illness/injury due to an AUTO or LIABILITY ACCIDENT? | | |
| Is the patient EMPLOYED AND COVERED BY THE EMPLOYER'S HEALTH PLAN? | | |
| Is the patient's SPOUSE EMPLOYED AND THE PATIENT IS COVERED BY THE SPOUSE'S EMPLOYER'S HEALTH PLAN? | | |
| Is the patient ENTITLED TO BENEFITS SOLELY ON THE BASIS OF END STAGE RENAL DISEASE? | | |
| Have you had Physical Therapy or Speech Therapy services already this year? | | |
| Are you receiving currently home care for ANY services (home health aide, dressing changes, blood work, injections, medications, suture removal)? | | |

Patient's Certification: I certify that the information given by me in applying for payment under TITLE XVIII of the SOCIAL SECURITY ACT is correct.

_____ _____ _____
Patient Signature Date Witness Signature