RIDGEWOOD PHYSICAL THERAPY AND REHABILITATION CENTER
PATIENT INFORMATION

Today's date: / /					**EMAIL:**	
PATIENT INFORMATION						
Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
SS#: - -	Birth date:		Sex: [ ] Male [ ] Female			
Street address:		Home #: ( )			Cell #: ( )	
	City:		State:		ZIP Code:	
Occupation:	Employer:				Employer phone no.: ( )	
Chose clinic because/Referred to clinic by (please check one box): ❑ Dr.						

INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Please indicate Primary Insurance:					
Member's name (patient): Is Patient a Minor? YES or NO	Member's ID Number:	Birth date: / /	Group no.:		
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other					
Subscriber's Name: **(Who is responsible for this account):**	Subscriber's Birth Date:				
Name of Secondary Insurance(if applicable):			ID#:		

ACCIDENT INFORMATION – MOTOR VEHICLE OR WORKMAN'S COMPENSATION ONLY

Is this condition due to an accident? [ ] Yes [ ] No If YES, please indicate DATE of accident: / /

Type of Accident: [ ] Auto [ ] Work [ ]Home [ ]Other

CLAIM NO #: ADJUSTER'S NAME AND TELEPHONE #:

Attorney Name(if applicable):

IN CASE OF EMERGENCY			
EMERGENCY CONTACT:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

ASSIGNMENT AND RELEASE

I CERTIFY THAT I, and/or my dependent(s), have insurance coverage with_____and assign
Name of Insurance Company(ies)

directly to Ridgewood Physical Therapy all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

Print and Sign: **Signature of Patient, Parent, Guardian or Personal Representative**

_____ _____

Today's Date **Relationship to Patient**

PATIENT CONDITION AND MEDICAL HISTORY

REASON FOR VISIT(BODY AREA OF INJURY):_____

WHEN DID YOUR SYMPTOMS APPEAR?:_____ **HOW OFTEN DO YOU HAVE THIS PAIN?**_____

IS THIS CONDITION GETTING PROGRESSIVELY WORSE? [ ]YES [ ]NO

RATE THE SEVERITY OF YOUR PAIN ON A SCALE FROM 1 (LEAST PAIN) TO 10(SEVERE PAIN): #_____

PLEASE TELL US AT LEAST 2 OR 3 OF YOUR NORMAL ACTIVITIES WHICH YOU ARE NOT ABLE TO PERFORM WITH YOUR PRESENT CONDITION. FOR INSTANCE UNABLE TO TUCK IN MY SHIRT, UNABLE TO WALK UP AND DOWN STAIRS.

These functional limitations are the reasons you are in need of physical therapy and in order for your insurance company to give coverage, they will want to know these limitations. Please do not list recreational activities.

1.

2.

3.

EXAMPLES: tying shoes, bending over, sewing a button, lifting a grocery bag, dressing yourself, driving, standing from an armless chair, picking something up off the floor, opening a door, opening a jar, squatting, sleeping, reaching out to a high shelf, throwing an object, washing yourself, walking a flight of stairs without a handrail, working on a computer, getting in/out of a car, fear of falling.

LIST MEDICATIONS	LIST RECENT SURGERY AND HOSPITALIZATIONS	FRACTURE/BROKEN BONES/FALLS

IMPORTANT PLEASE ADVISE US IF YOU CURRENTLY HAVE OR HAD A SKIN CONDITION/RASH

[ ] ANEMIA	[ ] HIGH BLOOD PRESSURE	[ ] NEUROLOGICAL PROBLEMS	
[ ] ANGINA	[ ] HEART ATTACK	[ ] NIGHT SWEATS	
[ ] ANXIETY	[ ] HEART PALPITATIONS	[ ] OSTEOPOROSIS	
[ ] ARTHRITIS	[ ] HEPATITIS	[ ] PACEMAKER	
[ ] ASTHMA/BRONCHITIS	[ ] HIV POSITIVE	[ ] PARKINSON'S DISEASE	
[ ] CANCER	[ ] HIGH CHOLESTROL	[ ] PEPTIC ULCER	
[ ] CARDIOVASCULAR PROBLEMS	[ ] LYMES DISEASE	[ ] POLIO	
[ ] CIRCULATORY PROBLEMS	[ ] LIVER DISEASE	[ ] **PREGNANT**	**# MONTHS**
[ ] DEPRESSION	[ ] LOW BLOOD PRESSURE	[ ] Skin Rash/Condition	
[ ] DIABETES	[ ] LUNG DISEASE	[ ] STROKE	
[ ] EATING DISORDER	[ ] MIGRAINE HEADACHES	[ ] THYROID PROBLEMS	
[ ] EMPHYSEMA	[ ] MUSCLE ACHES	[ ] URINARY/BOWEL PROBLEMS	
[ ] FAINTING	[ ] NEURITIS/NUMBNESS/TINGLING	[ ] VERTIGO/LOSS OF BALANCE	

[ ] LATEX ALLERGY **[ ] DO YOU HAVE ANY METAL IMPLANTS**

Signature of Patient/Parent/Guardian **Date**

Ridgewood Physical Therapy and Rehabilitation Center

104 Chestnut Street

Ridgewood, New Jersey 07450

Office 201 493 8111 Fax 201- 493 8279

OFFICE POLICY

CONSENT FOR CARE & TREATMENT:

Your Physical Therapist will complete an evaluation by examination and interview. Your individual treatment program will then be designed. A variety of techniques may be used.

I,_____the undersigned do hereby agree and give my consent for **Ridgewood Physical Therapy and Rehabilitation Center Inc.** to furnish physical therapy care and treatment considered necessary and proper in evaluating and treating my physical condition.

Patient Signature:_____Date:_____

PLEASE COMPLETE THIS PART ONLY FOR CONSENT OF THE TREATMENT OF A MINOR(UNDER 18 YEARS OF AGE):

As a Parent and/or Legal Guardian of_____, I authorize Ridgewood Physical Therapy and Rehabilitation Center Inc. to treat the minor patient named above while I am either present or not present in the facility.

Parent/Guardian Signature:_____Date:_____

Assignment of Benefits

I hereby assign all the professional, medical expense benefits and major medical benefits to which I am entitled to under my insurance policy held with:

_____ to Ridgewood Physical Therapy and Rehabilitation Center Inc.

I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, PIP carriers/ Workman's Comp Carriers and any other health/medical plan, to issue payment directly to

RIDGEWOOD PHYSICAL THERAPY AND REHABILITATION CENTER INC.
104 CHESTNUT STREET
RIDGEWOOD NJ 07450

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.
I authorize the use of my signature on all claim or appeal forms. A photocopy of this Assignment or statement of "signature on file" for claim forms shall be considered as effective and valid as the original.

Authorization to Release Information

I hereby authorize RIDGEWOOD PHYSICAL THERAPY to: (1) release any information necessary to insurance carriers regarding my illness and treatment; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature and this form to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

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

I authorize Ridgewood Physical Therapy to initiate an appeal or complaint to my health care provider or the Insurance Commissioner for any reason on my behalf.

Name of person signing (print): _____

Relationship to Insured: _____

Signature of Insured: _____Date: _____

Ridgewood Physical Therapy and Rehabilitation Center
104 Chestnut Street
Ridgewood, New Jersey 07450
Office 201 493 8111 Fax 201- 493 8279
www.ridgewoodpt.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES MEDICAL RECORDS RESTRICTION(S)

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

_____

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____ _____
Please print your name here Signature

_____
Date

Patient's Name:_____

DOB:_____ Social Security Number: XXX-XX-_____
(Last four numbers)

I understand, I have the right to request restrictions as to how my health information may be used or disclosed, and The Practice is not required to agree to the restriction(s) requested.

I want only the noted person(s) to have access to my medical information:

_____ _____
(Print) Name Date

_____ _____
(Print) Name Date

_____ _____
(Print) Name Date

It is my understanding ; I may revoke this consent(in writing) except to the extent The Practice has previously taken action in releasing this information accordingly.

_____ _____ ____/____/_____
(Print) Patient Signature Patient Signature OR LEGAL Authorized Representative Date

HIPPA Acknowledgement of Receipt of the Notice of Privacy Practices
This form does not constitute legal advice and covers only federal, not state, law.

WELCOME TO RIDGEWOOD PHYSICAL THERAPY. HERE ARE OUR BELIEFS ON WHAT WE FEEL WILL HELP YOU GET THE BEST OUT OF YOUR THERAPY EXPERIENCE DURING YOUR TREATMENT AT OUR FACILITY:

- ***"How long will physical therapy take?"***

Rather than setting a date to complete therapy by based on your prescription, set various goals that you would like to achieve during your rehabilitation program. Each individual's rate of healing is different. ***We know your time is valuable*** and we respect that by helping you to achieve your maximum goals regardless of the time taken to reach them.

- ***"How long is each session? How many times a week do I have to go?"***

You should **be prepared to stay for an hour** for each therapy session. The maximum amount of time is utilized each visit so that our patients receive the quality care. In conjunction with that your sessions can range between 2-3 times per week. It is important for your recovery for you to spend the time and days at Physical Therapy. Our therapists will administer ***the best care*** for your treatment.

- ***"Will I have the same therapist every treatment?"***

Our professionally trained staff work together as a team towards the best treatment for our patients. Each therapist works in conjunction with the other- before, during and after treatment including chart review, exercises and therapeutic treatment. This allows a different perspective for each patient's individual recovery process and maximizes your healing.

- ***"Is it okay to ask questions to my therapist while I am being treated?"***

  Yes! Knowledge is the best power in your recovery. Not only will our therapist provide you with the most information possible during your care here but we encourage you to communicate with all of us, your needs, expectations and especially your physical therapy goals.

- ***"What should I expect as a parent if my child is being treated for physical therapy?"***

  The purpose of therapy is to get your child back to doing what they love. Unfortunately, depending on the severity of their injury, recovery can take anywhere from a few days to as long as several months. Most of the time parents drop their child off for therapy and then end up calling with lots of questions or conflicting statements from their child-***attend a couple of PT sessions!*** Teenagers want to get back to their activities as soon as possible but a child's recovery from injury is no time for bargaining. If your child is rushed back from injury before they have been given enough time to completely recover simply increases the risk of future injury.

- ***"I have finished my treatment and reached all of my goals, now what happens?"***

  Congratulations! Our therapists and your diligence have helped you reach your physical goals during this treatment process. Therapists will provide you with a ***Home Exercise Program*** during your **"discharge"** session that is a complete and effective way for you to maintain long-term health based on your physical therapy sessions at our office.