INNOVATIVE PHYSICAL THERAPY & FITNESS CENTER

3562 Route 27, Suite 124
Kendall Park, NJ 08824

259 Talmadge Road
Edison, NJ 08817

Phone: (732) 853-8177
Fax: (732) 853-8169

OFFICE POLICY & PROCEDURES

Welcome to our practice. Thank you for your confidence and trust. We are dedicated to the quality care of all patients and are always here to discuss your problems and together find the best solution.

Please carefully read and initial each line of our office policies listed below:

_____ **Co-payments or payments are due at the time of service**. Payments can be made via credit card, personal check, or cash.

_____ **You are responsible for obtaining a Primary Care Physician referral or prescription** if required by your insurance company. **No visits will be back-dated for any reason.**

_____ We file all insurance claims for you. In most cases, insurance companies will make payment to our office directly. **If you receive payment for our services, you are responsible to bring the checks to our office no later than 30 days after being issued to you.**

_____ Please remember to make appointments and set aside time for each treatment session. In the event you are running late or need to reschedule appointments, **we expect at least 24-hour's notice**. **If we receive less than 24-hour's notice or you do not show up for your appointment (other than emergencies), your account will be charged a $50 fee.**

If at any time you are experiencing a problem regarding billing and payment, please do not hesitate to contact our office and we will be happy to assist you and answer your questions.

After you have carefully read the above, please sign the following:

I _____, agree to be treated by Innovative Physical Therapy & Fitness Center and its staff. I have read and understand all the terms specified above.

Signature: _____ Today's Date: _____

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PATIENT INFORMATION

(PLEASE PRINT)

Date: _____

First Name: _____ Middle Initial: ___ Last Name: _____

Gender: M / F Marital Status: M / S / D / W DOB: _____SS#_____

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

Home Phone: _____ Cell Phone: _____

Email Address: _____

Employer: _____ **Auto Related Injury: Y / N**

Position: _____ **Work Related Injury: Y / N**

Date of Injury: _____

Primary Care Physician: _____

Physician Date Last Seen: _____

Phone #: _____

How did you hear about us? (Please circle one) Doctor / Family / Friend / INS / Walk In / Other

If other, please explain: _____

Have you received Physical Therapy before? Y / N

If yes, when? _____

Emergency Contact Information

Name: _____

Relationship to Patient: _____

Phone #: _____

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INSURANCE INFORMATION
(MUST BE FILLED OUT)

Primary Insurance: _____

Member ID #: _____

Provider Phone #: _____

Group #: _____

Copay Amount: _____

Secondary Insurance: _____

Member ID #: _____

Provider Phone #: _____

Group #: _____

Copay Amount: _____

AUTHORIZATION TO RELEASE INFORMATION OF BENEFITS

I hereby authorize Innovative Physical Therapy & Fitness Center to apply for benefits on my behalf for covered services render by the Practice order. I request that payment from my insurance be made directly to Innovative Physical Therapy & Fitness Center. I authorize release of any medical information necessary to process this claim. I permit a copy of this assignment to be used in place of the original. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for any balance not covered by my insurance company.

Signature: _____ **Today's Date**: _____

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MEDICAL HISTORY

Name: _____ Date: _____

□ Allergies	□ Cerebral Palsy	□ HIV/AIDs	□ Pacemaker/Parkinson's
□ Anemia	□ COPD	□ Hypoglycemia	□ Polio
□ Arthritis	□ CVA (Stroke)	□ Kidney Disease	□ Psychological Disorder
□ Bone Loss (Osteoporosis, Osteopenia)	□ Diabetes	□ Liver Disease	□ Seizure Disorder
□ Cardiac (MI, Arrhythmia, Angina)	□ Hearing Loss	□ Lupus	□ Thyroid (Hyper, Hypo)
□ Cancer	□ High Blood Pressure	□ Multiple Sclerosis	□ Visual Loss

□ Other: _____

Past Surgeries	**Type:**	**Date:**
1.		
2.		
3.		

Have you ever broken any bones? Y / N If yes, where: _____

Past motor vehicle accidents? Y / N If yes, explain: _____

Are you taking any medications? Y / N If yes, please list: _____

Do you have any metal implants? Y / N If yes, where? _____

Are you, or do you think you may be pregnant? Y / N If yes, how many months? _____

Do you have children? Y / N Ages: _____

Do you smoke? Y / N If yes, when did you start? _____

What sports/recreational activities do you participate in? _____

Dominant Side of the Body? Right / Left

Briefly describe your present problem: _____

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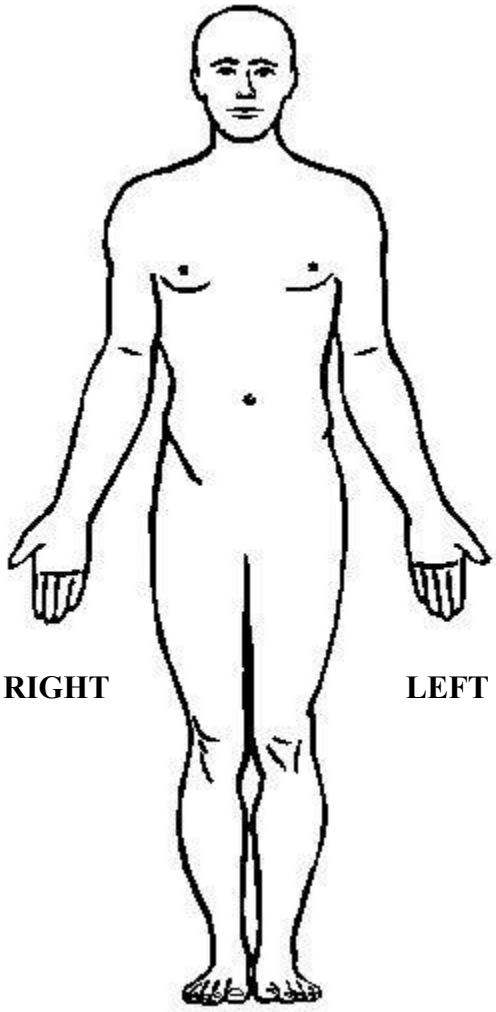
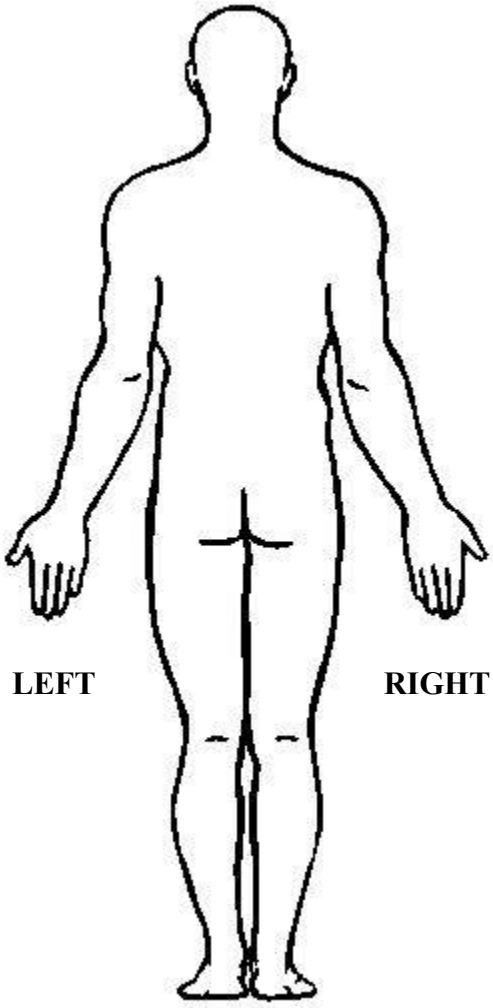
Name: _____ Date: _____

PLEASE INDICATE THE LOCATION OF THE AREA IN WHICH YOU ARE EXPERIENCING PAIN OR DISCOMFORT BY DRAWING A CIRCLE AROUND THE AREA.



RIGHT **LEFT**



LEFT **RIGHT**

□ CONSTANT

□ PERIODIC

□ BRIEF

INNOVATIVE PHYSICAL THERAPY & FITNESS CENTER

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, hereby acknowledge that Innovative Physical Therapy & Fitness Center has provided me with a copy if its Notice of Privacy Practices that described how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have any questions or complaints, I may contact: **Innovative Physical Therapy & Fitness Center at (732) 853-8177**.

I also understand that I am entitled to receive updates upon request if Innovative Physical Therapy & Fitness Center amends or changes its Notice of Privacy Practices in a material way.

Signature: _____Relationship to Patient: _____Date: _____

THIS SECTION IS TO BE COMPLETED BY INNOVATIVE PHYSICAL THERAPY & FITNESS CENTER IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above named patient, but was unable to because:

□ Patient declined to sign the Written Acknowledgement

□ Other (Specify): _____

_____

Name of Employee: _____ Date: _____