INNOVATIVE PHYSICAL THERAPY & FITNESS CENTER
3562 Route 27, Suite 124 259 Talmadge Road
Kendall Park, NJ 08824 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 backdated 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)

First Name: _____Middle Initial: ___ Last Name: _____

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

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

Home Phone: _____ Cell Phone: _____

Primary Care Physician: _____Physician Date Last Seen: _____

Phone #: _____

Appointment Reminder: Would you like to receive appointment reminders? Yes / No

Please indicate which method of appointment reminder you prefer: **Text** / **Call** / **Email**

Email _____

Emergency Contact Information

Name: _____ Relationship to Patient: _____Phone #: _____

INSURANCE INFORMATION
(MUST BE FILLED OUT)

Primary Insurance: _____ **Member ID** #: _____

Provider Phone #: _____

Secondary Insurance: _____ **Member ID** #: _____

Provider Phone #: _____

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 QUESTIONNAIRE

Is this injury related to a Motor Vehicle or Worker's Comp. Accident? Y/N **If yes, please notify us**.

Have you had surgery in relation to your current diagnoses? Y/N If, yes when _____

Do you have a pacemaker? Y/N

Are you currently pregnant? Y/N If yes, how many weeks? _____

Do you have a history of:

Yes	**Yes**	**Yes**	**Yes**
☐ Allergies	☐ Chronic Back Pain	☐ Heart Disease	☐ Osteoarthritis
☐ Arthritis	☐ Chronic Neck Pain	☐ Hep B/C	☐ Osteoporosis
☐ Angina	☐ Crohn's Disease	☐ High Cholesterol	☐ PVD
☐ Arrhythmia	☐ COPD	☐ HIV/AIDS	☐ Rheumatoid Arthritis
☐ Asthma	☐ CVA (Stroke)	☐ Hypertension	☐ Scoliosis
☐ Bipolar Disorder	☐ Diabetes Type 1/2	☐ IBS	☐ Seizure Disorder
☐ Blood Clotting	☐ Depression	☐ Joint Pain	☐ Shortness of Breath
☐ Cancer	☐ Hearing Loss	☐ Headaches	☐ Sleeping Disorder
☐ Carpal Tunnel	☐ High Blood Pressure	☐ MRSA	☐ TB
☐ Cardiac (MI, Angina)	☐ DVT	☐ MS	☐ Urinary Incontinence
		☐ MI/Heart Attack	

Briefly describe your symptoms _____

Dull Aching / Sharp / Stiffness / Shooting / Radiating / Burning / Numbness / Tingling

When did your symptoms start? _____

How did your symptoms begin? _____

How often do you feel your symptoms? Constant / Frequent / Occasional / Intermittent

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PLEASE MARK THE AREA OF INJURY OR DISCOMFORT ON THE CHART BELOW

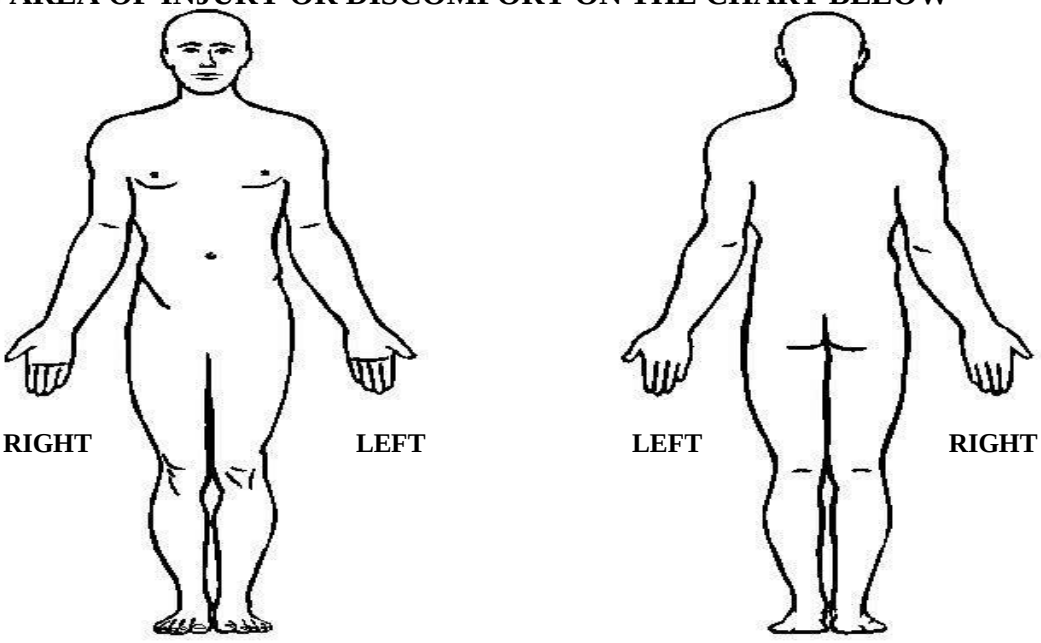
Pain Scale

0: No Pain – 10: Severe Pain

Current: _____

Best: _____

Worst: _____



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Designation of Authorization Representative for Appeals or to Request Information

I _____, hereby appoint Innovative Physical Therapy & Fitness Center as my authorization representative to act on my behalf in filing appeals relate to denied claim, reduction in payment, requested information and all other appeals pertaining to a denied claim.
Please forward all notices and communications concerning the outcome of an appeal to both Innovative Physical Therapy & Fitness Center and myself.

_____ _____ _____
Patient Signature Print Name Date

HIPPA – Consent for Release of Personal Information

I give permission to Innovative Physical Therapy & Fitness Center to:

Share information regarding my appointment schedule. Yes / No

Share information regarding my insurance benefits. Yes / No

If yes, with whom _____

CONSENT & ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____ **Consent**: I have been informed by my physician and/or Physical Therapist of the risks and benefits attendant to the course of treatment and/or therapy (hereinafter "treatment") prescribed by my physician and/or Physical Therapist. I understand that it is the opinion of the physician and/or Physical Therapist responsible for my care that the benefits of this treatment outweigh the risks of treatment. I fully understand the nature of these risks, including, but not limited to deterioration of my condition, re-injury and/or new injury. After careful consideration of these risks and benefits, I hereby CONSENT to allow Innovative Physical Therapy and Fitness Center and all personnel employed/contracted by Innovative Physical Therapy and Fitness Center to perform the treatment and/or therapy specified by my physician and/or Physical Therapist and deemed necessary and/or advisable by Innovative PT & FC, in accordance with my physician's and/or Physical Therapist's orders and standards of good clinical practice. I acknowledge that no promises or representations have been made to me regarding the outcome of this treatment. Despite precautions, I understand that Innovative PT & FC employees may accidentally come into contact with my blood or other bodily fluids as a result of providing the treatment. In case such an exposure, I agree that my blood may be tested to determine if I have been exposed to certain infectious diseases. The test results will only be used/disclosed as provided for by law. I agree that the results may be used for the diagnosis and/or treatment of the Innovative PT & FC employee(s) that were exposed.

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: _____