Ken S. Cheng, DPT, OCS, PES 4OQA013278 Date ____/_____/____

Dan Linick, PT, DPT 40QA01339700

Patient Name: _____

Acknowledgement of HIPPA

I acknowledge that I received, or was offered, information on HIPPA policy.

I authorize South Jersey Physical Therapy to discuss my Physical Therapy care with the following individuals.

_____
_____
_____

Initial _____

Consent to treatment:
I acknowledge that I am voluntarily seeking care from South Jersey Physical Therapy. I authorize a licensed Physical Therapist to conduct an evaluation to determine a plan of care. I further authorize a licensed Physical Therapist or licensed Physical Therapist assistant to provide treatment based on an agreed upon plan of care. I acknowledge that there are some risks inherent with Physical Therapy. I understand that I have the right to question any care being provided and refuse recommended treatments. I acknowledge that the Physical Therapist or Physical Therapist Assistant is acting in my best interest, and cannot guarantee that desired results will be obtained.

Initial _____

Consent to medical information:
When appropriate for my care, I authorize South Jersey Physical Therapy access to medical information from other providers, which includes, but is not limited to, imaging reports, operative reports, and physician notes.

Signature _____ **Date _____/_____/_____**
(Patient)

Signature _____ **Date_____/____/_____**
(Parent/Guardian if patient is a minor)

Phone: (609) 621-SJPT (7578)| **www.SouthJerseyPT.com** | Fax: (888) 219-7999

1299 Route 38, Suite 9, Hainesport, NJ 08036

Ken S. Cheng, DPT, OCS, PES 4OQA013278 Date ____/_____/____

Dan Linick, PT, DPT 40QA01339700

SOUTH JERSEY PHYSICAL THERAPY

Patient Name _____ DOB_____ Age _____

Address _____

City _____ State _____ Zip _____ Email _____

Phone _____ (home/cell work) Alt. Phone _____ (home/cell/work)

SSN ___/___/___

Emergency Contact _____ Relationship _____

Emergency Contact Phone Number _____ (home/cell/work)

Primary Care Physician Name _____ **Phone** _____

Referring Physician Name _____ **Phone** _____

How did you hear about South Jersey Physical Therapy (circle one):
Physician referral Previous Patient Internet Search Insurance Website Friend/Family

(Please specify) _____ **Other** _____

What type of problem (check all that apply):

Neck _____ Back _____ Hip _____ Knee _____ Ankle/Foot _____ Shoulder _____

Elbow _____ Hand/Wrist _____ Balance _____ Other (please specify) _____

Is this injury related to a motor vehicle accident? yes ____ no ____ if yes, give date _____

Is this injury related to a work accident? yes____ no_____ if yes, please give date _____

Are you currently employed? yes ____ no _____

If yes, name of employer _____ Job Title _____

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Have you ever served in the military? _____ yes _____ no

Are you covered under an employer or union policy? _____ yes _____ no

Is your spouse or other family member employed? _____ yes _____ no

Do you have a secondary insurance policy?_____ yes _____ no

Are you covered under any other healthcare plan? _____ yes _____ no

Insurance Information:

Primary Insurance _____

Insurance Number _____ Group Number _____

Subscriber (write self if self) _____ Subscriber DOB ____/____/___ Phone number _____

If accident, name of adjuster/case manager _____ Phone number _____ ext _____

Secondary insurance (or personal insurance if accident related) _____

Policy Number _____ Group Number _____

Subscriber (write self if self) _____ Subscriber DOB ____/____/___ Phone number _____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional service rendered. I have read all the information on both sides of this sheet and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify South Jersey Physical Therapy of any changes in my status or the above information.

Signature _____ Date _____/_____/_____
(Patient)

Parent/Guardian Name _____ Date_____/____/_____
(If patient is a minor)

Signature _____
(Parent/Guardian if patient is a minor)

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Date ____/_____/____

SOUTH JERSEY PHYSICAL THERAPY

History of Present Injury

What happened? _____

When did the most recent symptoms begin? _____

Have you had this problem before? _____ yes _____ no if so, when did the symptoms start _____

How would you describe your complaints? _____

Goal for Physical Therapy _____

Social

Please check off all that apply

Live with spouse/significant other _____ Family/more than 1 individual _____

One story _____ more than one store _____ stairs _____ railing _____ pets (dogs or cats) _____

Please list all prescription medication that you are taking

_____

_____

_____

Please list any over the counter medications that you are taking

_____

_____

_____

Are you pregnant, or could you be pregnant? ____yes ____no

Medical history (please check all that apply)

HIV ___ Hepatitis ___ Stomach Problems ____ Diabetes ____ Cancer ____ Heart Problems _____

Skin Disease ___ CVA ____ Kidney ____ Liver_____ TIA ____ Lung Problems _____ Circulatory Problems _____

Urinary Incontinence ___ Head Injury ____ Back/Neck Injury____

Please list any surgeries that you have had including date and type

_____

_____

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Date ____/_____/____

Please list any surgeries that you have had including date and type

_____

_____

_____

Please list any allergies that you have

_____

_____

_____

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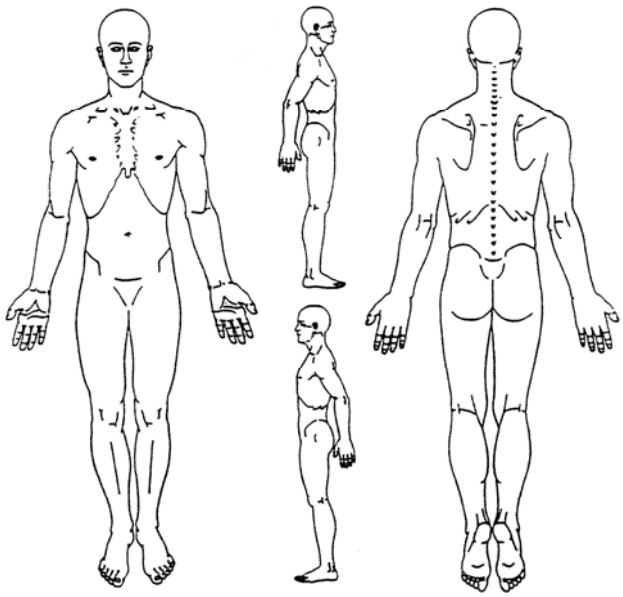
Date ____/_____/____

Current symptoms

Using the diagram below, mark the location and type of symptoms that you presently have



Use an X to mark pain location(s) with arrows to denote traveling pain
Use a circle to denote areas of numbness
Use ///// to denote areas of weakness (related to your symptoms)

Draw a line for your pain now

0 ---------- 10
(no pain) (extreme pain)

What number is your pain at best _____ at worst _____

Signature _____ Date _____/_____/_____
(Patient)

Parent/Guardian Name _____ Date_____/____/_____
(If patient is a minor)

Signature _____
(Parent/Guardian if patient is a minor)

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Ken S. Cheng, DPT, OCS, PES 4OQA013278 Date ____/_____/____

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Payment Authorization: (Initials required)

_____ **Assignment of Insurance Benefits**

Initials I authorize that the payment of my insurance benefits be made directly to South Jersey Physical Therapy LLC for all services delivered; if I am paid directly I will promptly pay South Jersey Physical Physical Therapy LLC all monies paid to me.

_____ **Certification of Information**

Initials I certify that the information I have provided South Jersey Physical Therapy LLC for payment, but not limited to, Related accidents, illnesses or other insurers is accurate and truthful.

I attest, to the best of my knowledge, the above information is accurate and true.

Signature/ Date:

_____ _____

Patient or Legal Representative's Signature **Today's Date**

Treatment Authorization

I authorize Physical Therapy treatment of myself or my minor child by the therapists and staff at South Jersey Physical Therapy, LLC.

Signature/ Date:

_____ _____

Patient or Legal Representative's Signature **Today's Date**

REFERRAL AUTHORIZATION:
Your insurance carrier may require a referral from your primary care physician for our services. Please be aware that it is your responsibility to obtain all necessary referrals prior to therapy. If your insurance carrier required an authorization for service, no service will be rendered until the authorization is obtained. Furthermore, we may be required to contact your doctor for a treatment order referral for services.

CANCELLATION AND/OR NO-SHOW POLICY:
South Jersey Physical Therapy LLC urges you to keep every appointment, as consistent treatment will expedite your recovery. In the event you need to cancel an appointment, we require at least 24 hours notice, excluding Saturday and Sunday. Patients who cancel without proper notice or fail to show for a scheduled appointment may be subject to a $25.00 charge for each occurrence. Arrival more than 15 minutes after your appointment time will be considered a cancellation.

NOTICE OF PRIVACY/CONFIDENTIALITY
In providing services to you, we create and store personal health information. We assure you that this information about you and your health will remain confidential and we are committed to protecting the privacy of this information. We must obtain your consent before treating you which allows us to release such information to your physician and private insurance companies/third party payors, to secure payment for our services and conduct specific health care operations for this practice.

I understand all that is listed above and consent to the Physical Therapy treatments offered or recommended to me by my Doctor and/or Physical Therapist. I intend this consent to apply to all my present and future Physical Therapy care.

_____
Printed Name

_____ _____
Patient or Guardian Signature Date