GOOD HANDS PHYSICAL THERAPY

"Experience the difference"

Appt Date: _____ **Who referred you to GHT? _____**

Time: _____ **Therapist: _____**

How you heard of Good Hands Physical Therapy: _____

PATIENT INFORMATION

Name:_____

Date of Birth: _____ SSN: _____

Address: _____

City: _____State: _____

Zip: _____

Sex: M F

Marital Status:

Single _____ Widowed _____ Minor _____

Married _____ Separated _____ Divorced _____

Patient Employer / School: _____

Employer / School Address: _____

Responsible Party:_____

Relationship:_____

Employer Address:_____

ACCIDENT INFORMATION

Is this condition due to an accident? Yes _____ No_____

Date of Injury_____

Type of accident: Auto _____ Work _____ Home _____ Other ____

Have you made a report of your Accident? Yes _____ No _____

CONTACT INFORMATION

Home Phone: _____

Cell Phone: _____

Work Phone: _____

E-Mail Address: _____

EMERGENCY Contact

Name :_____

Relationship: _____

Home Phone: _____

Cell Phone: _____

PRIMARY CARE PHYSICIAN

Name: _____

Phone: _____

Address: _____

_____

REFERRING PHYSICIAN

Name: _____

Phone: _____

Address:_____

_____

Villa Plaza, 478, NJ-28, Bridgewater, NJ 08807 (Next to Gold Gym)

Phone - (908) 323 5753 / Fax - (908) 300 3741 / Email :- rashmi@goodhandspt.com / www.goodhandspt.com

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PATIENT CONDITION

Reason for visit:_____

When did your symptoms appear?_____

Is this condition getting progressively worse? Yes No Unknown

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) Type of Pain:

Sharp_____ Dull _____ Throbbing_____ Numbness _____ Aching_____ Shooting_____

Burning_____Tingling_____ Cramps_____ Stiffness_____ Swelling_____ Other_____

How often do you have this pain? _____

Is it constant or does it comes and goes? _____

Does it interfere with?

Work _____ Sleep _____Daily Routine _____ Recreation_____

Activities or movements those are painful to perform:

Sitting_____ Standing_____ Walking_____ Bending_____ Lying Down_____

HEALTH HISTORY FORM

What treatment have you already received for your condition? Medications Surgery Physical Therapy Chiropractic Services None
Other_____

Name and address of other doctor(s) who have treated you for your condition_____

Date of last: Physical Exam_____ Spinal X-ray_____ Blood Test_____
Spinal Exam_____ Chest X-ray_____ Urine Test_____
Dental X-ray_____ MRI, CT-Scan, Bone Scan_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following

AIDS/HIV	YES NO	Glaucoma	YES NO	Tonsillitis	YES NO	Pneumonia	YES NO	Chemical Dependency	YES NO
Diabetes	YES NO	Mononucleosis	YES NO	Bleeding Disorders	YES NO	Ulcers	YES NO		
Liver Disease	YES NO	Stroke	YES NO	Heart Disease	YES NO	Cancer	YES NO	High Cholesterol	YES NO
Rheumatic Fever	YES NO	Appendicitis	YES NO	Pacemaker	YES NO	Herpes	YES NO	Psychiatric Care	YES NO
Alcoholism	YES NO	Goiter	YES NO	Tuberculosis	YES NO	Polio	YES NO	Chicken Pox	YES NO
Emphysema	YES NO	Multiple Sclerosis	YES NO	Breast Lump	YES NO	Vaginal Infections	YES NO	Kidney Disease	YES NO
Measles	YES NO	Suicide Attempt	YES NO	Hepatitis	YES NO	Cataracts	YES NO	Rheumatoid Arthritis	YES NO
Scarlet Fever	YES NO	Arthritis	YES NO	Parkinson's Disease	YES NO	High Blood Pressure	YES NO		
Allergy Shots	YES NO	Gonorrhea	YES NO						
Epilepsy	YES NO	Mumps	YES NO	Tumors; Growths	YES NO	Prostate Problem	YES NO	Other:_____	
Migraine Headaches	YES NO	Thyroid Problems	YES NO	Bronchitis	YES NO			_____	
		Asthma	YES NO	Hernia	YES NO	Whooping Cough	YES NO		
STD	YES NO	Gout	YES NO	Pinched Nerve	YES NO				
Anorexia	YES NO	Osteoporosis	YES NO	Typhoid Fever	YES NO				
		Herniated Disk	YES NO	Bulimia	YES NO				

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EXERCISE	WORK ACTIVITY	HABITS	
None	Sitting	Smoking	Packs/Day_____
Moderate	Standing	Alcohol	Drinks/Week_____
Daily	Light Labor	Coffee/Caffeine	Drinks(Cups)/Day_____
Heavy	Heavy Labor	High Stress Level	Reason_____

Are you Pregnant? YES NO Due Date_____

Injuries/Surgeries you have had:

Falls _____

_____**Date:** _____

Head Injuries _____

_____**Date:** _____

Broken Bones_____

_____**Date:** _____

Dislocation_____

_____**Date:** _____

Surgeries_____

_____**Date:** _____

OTHER INFORMATION

_____

_____

_____

_____

_____

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize Good Hands Therapy Associates, LLC., to obtain my Protected Health Information including, but not limited to, History and physical exam, lab reports, progress notes, X-Ray reports, substance abuse (including alcohol/drug abuse), Mental Health (including psychotherapy notes), HIV related information (including AIDS related testing).

I understand that this authorization will expire 365 days from the date I have signed this form and that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified, except to the extent action has already been taken in reliance upon it. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.

PRIVACY NOTICE

By my signature below, I acknowledge that I have received a copy of this practice's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law and understand my rights as a patient regarding my personal health information.

TREATMENT COMMITMENT

Good Hands Therapy cares very much about each person we treat. We are committing to you, our patient, to deliver Exceptional Care, with Exceptional Results! We request of you, our patient, a commitment to help us deliver what we promise, by understanding what is required of you. You play a large role in your health by the actions you choose to take. Listed are some of your responsibilities as a patient at GHPT:

1. Attending, on time, all scheduled appointments.
2. Informing your therapist of your progress, each visit.
3. Compliance with your treatment plan developed by your therapist.
4. Asking questions when you do not understand any instructions given to you by our staff.
5. Notifying your therapist in advance of your next doctor's appointment. **PATIENT MISSED APPOINTMENT POLICY**

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well-being and gain of your abilities is something everyone in our clinic takes quite seriously. Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore we have certain rules that need to be followed in order to ensure the most optimum results.

In an instance of cancellation, without 24 hours' notice, we reserve the right to charge you a $25.00 fee. In an instance of a no-show you will be charged a $50.00 fee. After the second no-show or third cancelled appointment all future appointments will be removed from the schedule and you will be added to our "same day appointment only" list.

In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care and will inform your physician of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

By signing, Patient agrees & understands all items outlined above

_____ _____

Signature of Insured/Patient Date

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FINANCIAL POLICY

We are committed to providing you with the best in Therapy care. In order to do this without compromising our patients; this policy has been implemented for each patient. If you have medical insurance, we are anxious to assist you in receiving your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

Payment for services is due at the time services are rendered unless other acceptable and agreed upon arrangements have been approved in advance by our staff. We accept cash, checks, Visa, MasterCard and Discover. We will be accommodating to you in the process of seeking reimbursement from your Insurance carrier. In special instances we may accept assignment of insurance benefits.

Deductibles and Co-payments must be made at each visit. It is our policy to collect a percentage of each visit or the entire fee until a deductible has been reached.

Please be further advised that Returned checks and balances older than 30 days from your Treatment discharge may be subject to additional collection and legal fees, as well as, interest charges of 1.6% per month.

If you participate with our in network groups such as MEDICARE, BCBS, AETNA, UHC, CIGNA and Johns Hopkins Healthcare Group, we will bill your insurance company and accept assignment of benefits. You will be responsible for any co-pays or deductibles at each visit. We will verify your coverage and determine your out of pocket cost prior to Treatment starting. We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier.
3. Not all services and diagnosis codes are a covered benefit in all insurance contracts.
4. We will not COMPRISE patient care based on an insurance companies "FEE SCHEDULE".
5. Verification of your insurance benefits is not a guarantee that payment will be made.

In cases involving Auto Claims and worker's Compensation, we will ONLY accept payment directly from the patient or from their insurance company and will arrange to accept payments from attorneys on a case by case basis. If a patient has instructed their insurance company to send payment to their attorney, the patient will be billed and held solely responsible and accountable for their bill. We will accept settlements on auto accounts only after prior approval and a letter of protection is on file.

We must emphasize that as a Medical provider, our relationship is with you, not your insurance company. While the filing of an insurance claim is a courtesy that we extend to our patients, all charges are your responsibility from the date the services were rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above policy or any uncertainty regarding your insurance coverage, PLEASE don't hesitate to ask us. WE ARE HERE TO HELP YOU!

_____ _____

Patient's Signature/Insured **Date**

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ASSIGNMENT OF MEDICAL BENEFITS, PAYMENT RESPONSIBILITY AND AUTHORIZATION FOR TREATMENT

PATIENT: _____

1. THE UNDERSIGNED, hereby authorize Good Hands Therapy Associates, LLC and its affiliates ("Provider") to render to Patient physical therapy, occupational therapy, speech therapy or other related services (collectively, "Therapy Services") that Provider or Patient's treating physician determines may be necessary or advisable. Patient agrees to cooperate with all reasonable requests by Provider in connection with Provider's rendition of Therapy **Services.**
2. THE UNDERSIGNED, hereby certify that all information provided to Provider by the undersigned or Patient, including any information in connection with applying for a payment under Title XVIII of the Social Security Act, is true and accurate in all respects.
3. THE UNDERSIGNED, hereby authorize Provider to disclose any information, furnished to Provider or obtained by provider in connection with Patient's treatment (including information concerning a related Medicare claim), to any physician, governmental agency (including the Social Security Administration or any of its intermediaries or carriers), insurance company or health care facility requesting such information.
4. THE UNDERSIGNED, hereby assign to Provider all Medicare benefits and Medicaid benefits to which Patient may be entitled for any Therapy Services rendered by Provider. The undersigned hereby authorize and direct Provider to apply and file for all such benefits on behalf of Patient. In the event Patient is covered by both Medicare and Medicaid, Patient's Medicare deductible and any applicable Medicare co-payment will be covered by Medicaid. The undersigned acknowledge that Provider has disclosed to the undersigned that Provider is a supplemental Medicaid provider and that Provider is paid directly by Medicaid. In addition, the undersigned approves contact with the appropriate family members for medical claims management purposes.
5. THE UNDERSIGNED, hereby assign to Provider all private medical insurance benefits (primary and secondary, including med. Gap providers) or other benefits to which Patient may be entitled for any Therapy Services rendered by Provider. The undersigned hereby authorize and direct provider to apply and file for all such benefits on behalf of Patient.
6. THE UNDERSIGNED, authorizes Good Hands Therapy Associates to deposit checks received on Patient's account when made out to the patient or signed over by the patient when Insurance Company pays against **services provided.**
7. THE UNDERSIGNED, agree that the undersigned shall be jointly and severally financially responsible for any portion of Provider's invoice that is not paid, except in the event of Medicare denial or Medicaid eligible recipients. The undersigned warrant and represent to Provider that Patient is not a member of, or covered by, a health maintenance organization or similar arrangement. The undersigned shall be liable to Provider for all services rendered by Provider in the event Patient is covered by a health maintenance organization or similar arrangement.
8. THE UNDERSIGNED and patient agree to execute any documents and perform any acts that Provider may reasonably request. The undersigned warrant and represent that attached hereto are originals or certified copies of any applicable powers of attorney, health care surrogate forms or court orders appointing the undersigned as the legal guardian of Patient.
9. THE UNDERSIGNED, agree that the provisions hereof shall continue in full force and effect until Provider has received written notice of termination signed by the undersigned; provided, however, that the provision of paragraphs 2, 4, 5, and 6 shall survive any such termination.
10. THE UNDERSIGNED, acknowledge that Provider has disclosed to the undersigned that no physician owns any **interest to Provider.**
11. THE UNDERSIGNED understands that they have a choice or rehabilitation service providers.

_____ _____

Patient's Signature/Legal Representative/Insured Party **Date**

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