Riverwalk Physical Therapy, L.L.C.
PATIENT SUMMARY

Date_____

PERSONAL INFORMATION

Name_____ Date of Birth_____

Street Address_____ Age_____ Gender: ☐ Male ☐ Female

City_____ State_____ Zip_____

CONTACT INFORMATION

Cell Phone _____ Home Phone _____
(Parent/Guardian's # if patient under 18 years old)

Email _____ Work Phone _____
(automatic 24hr advance appointment reminders)

Parent/Guardian Name_____ Phone_____
(if patient under 18 years old)

Emergency Contact_____ Phone_____

Contact Relationship: ☐ Spouse ☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Guardian ☐ Other

MEDICAL HISTORY

Referring Physician _____ Location_____

Primary Care Physician _____ Location_____

Date of next Physician visit _____

Please check the appropriate response	**Yes**	**No**
Is your current condition auto accident related?		
Is your current condition work related?		
Have you received or are you receiving physical, occupational, massage, chiropractic or pain management from any other facility or provider at this time? If yes, please explain		

Whom may we thank specifically for this referral?

Riverwalk Physical Therapy, L.L.C.
HEALTH QUESTIONNAIRE

Patient Name _____ Date _____

1) Date of Injury _____Date of Surgery (if applicable) _____

2) Please describe your symptoms (including how & when they started, aggravating & relieving factors, etc.)

_____

_____

_____

3) How often do you experience your symptoms?
☐ Constantly (100% of the day) ☐ Frequently (25-75% of the day) ☐ Intermittently (0-25% of the day)

4) What describes the nature of your symptoms?
☐ Sharp ☐ Dull Ache ☐ Numb ☐ Burning ☐ Shooting ☐ Tingling

5) How are your symptoms changing? ☐ Getting Better ☐ Not Changing ☐ Getting Worse

6) During the past 4 weeks:
Indicate the average intensity of your symptoms: 0 1 2 3 4 5 6 7 8 9 10
None Worst Imaginable

7) Who have you seen for your symptoms?
☐ Medical Doctor ☐ Chiropractor ☐ No One ☐ Other _____

What treatment did you receive?_____ When?_____

What tests have you had? X-Rays _____ (date) MRI _____ (date) Other _____ (date)

8) Have you had similar symptoms in the past? ☐ Yes ☐ No

If yes, please explain_____

9) In general, your overall health right now is? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

10) Do you exercise regularly? YES / NO

11) How would you consider your occupation? ☐ active ☐ sedentary

12) How would you describe your dietary habits? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

13) Do you smoke? YES / NO If yes, how many packs a day?_____ For how many years?_____

14) How much sleep do you get per night? _____

HEALTH QUESTIONNAIRE continued…

Please check/circle if you have ever (in your life) had, or do you presently have any of the following:

☐ Osteoporosis
☐ Bone Joint Problem
☐ Arthritis/Rheumatism
☐ Allergies
☐ Back Trouble
☐ Breathing Problems (any kind)
☐ Broken Bones/Dislocation/Sprains
☐ Cancer or Tumor
☐ Skin Disease or Sores that won't heal
☐ Dizziness/Fainting
☐ Epilepsy/Seizure Disorder
☐ Fibromyalgia Syndrome
☐ Headaches/Migraines
☐ Head/Spinal Injury
☐ Heart Disease/Chest Pain
☐ High Blood Pressure
☐ High Cholesterol
☐ Other (explain) _____
☐ Pacemaker/Defibrillator
☐ Pregnancy (current)
☐ Hernia/Rupture
☐ Diabetes - Type I / Type II
☐ Stroke/Neurological history
☐ Swelling of Feet or Joints
☐ Urinary Incontinence
☐ Surgeries (list below)

_____

_____

_____

Surgery/ Procedure	Date

MEDICATIONS

Are you allergic to any medications? YES / NO If YES, what?_____

If you are currently taking any medications please list below

1		5	
2		6	
3		7	
4		8	

I certify that I have reviewed and understand the above information supplied by me, and that it is true and correct to the best of my knowledge. I hereby consent to such treatment, procedures and patient care which, in the judgment of my physical therapist and/or physician, may be considered necessary or advisable while a patient at Riverwalk Physical Therapy, LLC.

Patient Signature _____ Date_____

Riverwalk Physical Therapy, LLC

ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

Authorization to Release Information

I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to the Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to the Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Financial Responsibility

I have requested professional services from RIVERWALK PHYSICAL THERAPY, LLC, ("Provider") on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advanced.

I hereby instruct and direct _____Insurance Company to pay by check made out and mailed to: **RIVERWALK PHYSICAL THERAPY, 665 MARTINSVILLE ROAD, BASKING RIDGE, NJ 07920**. or If my current policy prohibits direct payment to Riverwalk Physical Therapy, LLC., I hereby also instruct and direct you to make out the check to me and mail it as follows: **RIVERWALK PHYSICAL THERAPY, 665 MARTINSVILLE ROAD, BASKING RIDGE, NJ 07920** for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. If payment is mailed directly to me I will bring in the check and explanation of benefits within 1 week of receipt.

ERISA Authorization

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

Patient or Parent/Guardian Signature_____ Date_____

Riverwalk Physical Therapy, L.L.C.
AUTHORIZATION TO RELEASE INFORMATION

RELEASE OF INFORMATION I, the below named patient, hereby authorize Riverwalk Physical Therapy to release to any third party (such as an insurance company or governmental agency, example: Anthem BC/BS, UHC, or Medicare) any medical condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

PRIVACY PRACTICES I, the below named patient, understand that I am entitled to certain privacy rights regarding protected health information according to the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I also understand and have been given the opportunity to receive a copy of the entire Notice of Privacy Practices prior to signing this consent and understand that I may revoke this authorization in writing, except to the extent that action has already been taken.

CONSENT TO DISCLOSE PATIENT INFORMATION / HIPPA I, the below named patient, parent or guardian understand this center's Notice of Privacy Practices and give permission for my (my child's, child under my guardianship) protected health information to be disclosed for the purposes of communicating results, findings, care decisions, legal matters and appointments/scheduling to my doctors involved in my care as well as my lawyer representing me, as well as the family members listed below.

CONSENT TO LEAVE MESSAGES ON YOUR ANSWERING MACHINE (please initial one answer below):

YES Please leave me messages _____ **NO** Please do not leave me messages _____

FAMILY MEMBERS AND/OR LEGAL GUARDIAN (Please list family members and legal guardians below that may have access to information about you or your child from Riverwalk Physical Therapy, LLC)

1

2

3

Patient Name (please print)_____

Patient or Parent/Guardian Signature _____ Date_____

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ATTENDANCE POLICY

At Riverwalk Physical Therapy we strive to give all patients the personal attention they deserve. The following guidelines have been established in order to achieve this goal. Please sign your agreement to our attendance policy below.

1) I understand that if I am late for a scheduled appointment, I may not be able to be seen that day.
2) If I need to cancel an appointment, I will give **24 hours** in advance to notify the office. I will leave a voicemail if my call is not during normal business hours. I understand there is a $70.00 fee for a cancellation without proper notice. I understand that this will be billed to me and is not covered by insurance. (Last minute emergencies are excused of course)
3) I understand there is a $70.00 fee for missing a scheduled appointment without any notification. I understand that this will be billed to me and is not covered by insurance. (Last minute emergencies are excused of course)
4) I understand that if I miss 2 or more consecutive appointments without notice, I may be discharged from physical therapy.

Patient or Parent/Guardian Signature _____ Date_____