

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 \_\_\_\_\_

<b>Please check the appropriate response</b>	<b>Yes</b>	<b>No</b>
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 \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

1) Please indicate date of: Onset / Injury / Surgery \_\_\_\_\_  
(please circle one) (date)

2) Please describe your symptoms (including how 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 \_\_\_\_\_ MRI \_\_\_\_\_ Other \_\_\_\_\_  
(date) (date) (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:

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

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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 / FINANCIAL RESPONSIBILITY/ ERISA AUTHORIZED**  
**REPRESENTATIVE FORM**

**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.

**Financial Responsibility**

I have requested professional services from 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. 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 as well as any denied services.

If your insurance company requires scripts, doctor's notes or referrals, it is your responsibility to bring them to your appointment. Failure to do so may result in either rescheduling your appointment or you being responsible for payment at the time of service.

I hereby instruct and direct \_\_\_\_\_ Insurance Company to pay by check made out and mailed to: **RIVERWALK PHYSICAL THERAPY, 25 MOUNTAINVIEW BLVD, STE 207, 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, 25 MOUNTAINVIEW BLVD, STE 207, 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/HIPAA/ATTENDANCE-  
CANCELLATION POLICY**

**Authorization to Release 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 (HIPAA). 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 / HIPAA** 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.

Patient Name (please print) \_\_\_\_\_

Patient or Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

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**ATTENDANCE-CANCELLATION POLICY**

At Riverwalk Physical Therapy we value your business and appreciate your cooperation with our cancellation policy. We understand that there are times when a patient must miss an appointment due to an emergency or another unforeseen obligation. However, when a patient misses an appointment or calls less than 24 hours in advance they are preventing another patient from utilizing that time. Please sign your agreement to our attendance/cancellation policy below.

- Appointments must be cancelled at least 24 hours in advance to avoid cancellation fees. Missed and or cancelled appointments made without 24 hour advance notice will be charged at \$70.00. I understand that this will be billed to me and is not covered by insurance.
- Late arrivals - please keep in mind that arriving late for your appointment may require us to shorten the length of the treatment.

Patient or Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**Riverwalk Physical Therapy, L.L.C.**  
**ACKNOWLEDGEMENT OF RESPONSIBILITY**

To our valued patients:

Some insurance companies instruct providers to request that patients pay the bill in full at the time services are rendered; however, we do not want to put that financial burden on our patients. As a professional courtesy, we will submit to your insurance company for you and when you receive their correspondence and/or payment, you can provide it to us at our office.

Please note that we provide such services to our patients as long as the following is agreed upon by initialing below:

- I understand that I may receive the correspondence/checks from Aetna/Cigna/BCBS/UHC/GHI/Other (circle one). I agree to give the payment AND copies of all correspondence to the office within 14 days of receiving the information myself \_\_\_\_\_(initial please).
- I understand that I need to turn over copies of ALL correspondence I receive, even if there is no check attached. I have been advised that these "Explanation of Benefits" (EOB's) may show other valuable information such as deductibles applied and other denials which my provider may need to review for appeal/resubmission \_\_\_\_\_(initial please).
- I understand that my insurance company may only provide limited information about claims payment. If there is a claim that my insurance company states was processed to me which I insist was not received, I understand that I may need to have a conference call with my carrier, your billing office and myself \_\_\_\_\_(initial please).
- I understand that if I cash an insurance check, I will be responsible for the 3% surcharge if I pay the amount issued via credit card instead of providing a personal check \_\_\_\_\_(initial please).

Again, thank you for being our patient and we are glad to provide this service for you, we just ask that you work with us while we assist in having your claims processed.

I agree with the policy as stated above:

Patient or Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**RIVERWALK**  
PHYSICAL THERAPY

LIVE BETTER



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As a courtesy to our patients, we offer the option of paying on a weekly basis. If you prefer to make payments this way, instead of paying your cost at each visit, we require your credit card authorization on file.

Please provide your credit card information below:

Name on Card \_\_\_\_\_

Account Number \_\_\_\_\_

Expiration Date \_\_\_\_\_

3 or 4 digit security code \_\_\_\_\_

Signature \_\_\_\_\_

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**Riverwalk Physical Therapy**

25 Mountainview Blvd., Suite 207, Basking Ridge, NJ 07920  
Phone: 908-758-1006 Fax: 908-360-0511 [www.riverwalkpt.com](http://www.riverwalkpt.com)