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

Best Contact Number: Cell Phone_____ (Parent/Guardian's # if patient under 18 years old)

If not cell phone number, please circle Work or Business and list phone number: _____

Email _____
(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 _____

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:

☐ 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 / 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_____

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:

- **Attention BC/BS patients only**, some plans will send checks directly to the patient, made payable to the patient instead of sending them directly to our facility in our name. These checks need to be brought into our office attached to an Explanation of Benefit(s). Your co-insurance that you pay, along with the checks you will receive from your insurance company is payment in full. I agree to give the payment AND copies of all correspondence to the office within 14 days of receiving the information myself. Checks not received by Riverwalk Physical Therapy will be given 60-days of grace period. Following the 60-day period, interest will accrue at 1.5% per month for those checks not delivered to Riverwalk Physical Therapy

  _____(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 deposit an insurance check and pay the amount issued via credit card, I will be responsible for a 3% surcharge in addition to the monies owed. Monies paid by providing a personal check/bank check/postal money order/cash will not incur any additional fee or surcharge

  _____(initial please)

We appreciate your business and thank you for being our patient. 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 and was given a copy for my records:

Patient or Parent/Guardian Signature_____ Date_____

Signed copy: Front Desk Initials _____

RIVERWALK
PHYSICAL THERAPY
LIVE BETTER

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 _____

Riverwalk Physical Therapy
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