Healing HandZ
Physical Therapy
161 Lincoln Hwy., Unit-A
Edison, NJ 08820
Tel. (732) 902-2700
Fax. (949) 862-7791
www.HealingHandZ.com

Patient Full Name: ____ **Date:** _______________________________

1. **What are your symptoms?**____
   ____
   ____

2. **Which of the following best describes how your injury occurred?**
   Lifting Trauma Unknown Car Accident Degenerative process
   Cumulative trauma / overuse A fall During recreation/sports Other: _______________

3. **Where did your injury occur?**
   At work Auto Personal home Unsure other premise: _______________________

4. **Date of injury / onset of symptoms:** _____________/_____________________________

5. **Nature of symptoms (check all that apply):**
   Dull Aching Tingling Occasional Sharp Constant Throbbing Other

6. **Please state your pain level on a scale of 0 – 10** (Zero = no pain, 10 = hospitalized by pain): ___/10

7. **Prior to this onset, were you free of these symptoms?** Yes No
   If you answered No, Please explain ____

8. **Have you had any operations on the body region associated with your present symptoms?**
   Yes, date ___________ No

9. **Does the pain wake you at night?** Yes No

10. **Are your symptoms worse in the**: ☐ Morning ☐ Afternoon ☐ Evening

11. **What makes your symptoms worse? (Check all that apply)**

☐ Sitting	☐ Going to/from sitting	Coughing/sneezing	☐ Standing
☐ Walking	☐ Sleeping	Taking a deep breath	☐ Squatting
☐ Looking up overhead	☐ Reaching out/overhead	Reaching behind back	☐ Sports/recreation act
☐ Sustained bending	☐ Lying down	Swallowing	☐ Up/down an incline
☐ Chewing	☐ Stress	Up/down stairs	☐ Vacuuming
☐ Doing dishes	☐ Making the bed	Sports/recreation act	☐ Other_____________

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12. What relieves / lessens your symptoms?

Sitting Standing Lying down Changing positions Rest ☐ Alcohol
Exercise Heat Cold Massage **Medicine** ☐ Stretching
Nothing Other:____

13. What previous treatment have you had?

☐ None ☐ Physical Therapy ☐ Bracing/taping ☐ Medication ☐ Injections
☐ Exercise ☐ Traction ☐ TENS unit ☐ Massage therapy
☐ Manipulation/adjustment by a Osteopath or Chiropractor ☐ Other ____

14. Have you had any of the following?

X-rays MRI CT Scan Arthrogram EMG Other:__________________________________

15. Are you currently working? No Yes Full-Time Part -Time Restricted Duty
Occupation (specify) ____

16. What positions are you in while working? (Check all that apply)

☐Standing ☐ Sitting ☐ Walking ☐ Bending Lifting lbs _____ **Frequency** _____

17. FUNCTIONAL STATUS/ACTIVITY LEVEL (Check all that you have difficulty with)

Difficulty walking/movement transfers (such as moving from bed to chair, from bed to Commode)
Bed mobility gait (walking) **a.** _ on level **b.** on stairs **c.** on ramps **d.** on uneven terrain
Difficulty with self-care (such as bathing, dressing, eating, toileting)____________________________
Difficulty with home management (such as household chores, shopping, driving/transportation, care of dependent(s)____
Difficulty with community and work activities/integration
Work/school Household Activities Recreation or play activity
Other activities that you cannot perform because of pain.______________________________________

18. What goals would you like to achieve from therapy?

1.________________________________ 2. ________________________________
3.________________________________ 4. ________________________________
5.________________________________ 6. ________________________________

19. Have you had, or do you currently have, any of the following medical conditions?

Cancer Heart Disease Pacemaker High Blood Pressure ☐ Diabetes
Breathing diff. Pregnant– current Bone/joint disorders Recent surgery (this year)
Joint Replacement History of seizures Depression

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20. Past Medical History:____

____

21. LIVING ENVIRONMENT

Does your home have:	**Do you use:**
Stairs, no railing	Cane
Stairs, railing	Walker
Ramps	Manual wheelchair
Elevator	Motorized wheelchair
Uneven terrain	Glasses, hearing aids Other:
Assistive devices	Other_________________

Any obstacles: ____

22. Where do you live?

Private Home	Rental Apartment	Senior Apartment
Long Term Facility (nursing home)	Assisted living/group home	Other____________________

23. Who do you live with?

Alone	Spouse Only	Child	Other relatives
Group setting	Personal Care Attendant	**Other:**_________________	

24. List **medications** (including prescribed pills, skin patches, injections, vitamins/supplements and over the counter medicines) you are currently on and their prescribed purpose. Attach list if needed.

____

____

____

25. Who can we call in case of emergency?

1. Contact's Name: ________________________________ Relationship: _____________________________

   Phone Number: ________________________________ 2nd Ph. No. _____________________________

2. Contact's Name: ________________________________ Relationship: _____________________________

   Phone Number: ________________________________ 2nd Ph. No. _____________________________

26. Primary Care Physician's Name:_______________________ **Phone Number:**______________________________

Patient Signature: ____ **Date:** _______________________________

PATIENT INFORMATION

❑ *New Patient* ❑ *Established PT*

Patient's FIRST Name: MIDDLE: LAST:				Social Security #:
Birth date:	Sex: M F	Marital status (circle one) Single Mar Div Sep Wid	Employment Status (circle one) Employed Retired Student Not-Employed	Employer Name:
Your Address:	City		State:	Zip Code:
Race: Decline White American Indian /Alaska Nat. Asian Black/African American Nat.Hawaii/Oth Pac Islander Other		Ethnic Group: Non-Hispanic Hispanic/Latino Decline	Language: ❑English ❑Spanish ❑Other:________	
Primary Phone#: Cell Work Home	Alternate Phone#: Cell Work Home	Email Address: Appointment reminder by email? Yes No		
Referring Physician Name:	How did you hear about our office?			
Primary Physician Name:	Reason for visit: Date of Inj/Onset:			

RESPONSIBLE PARTY:

Person Financially Responsible [Guarantor] Self Only→Skip to insurance section Other Guarantor→Complete this section	Guarantor's Full Name:	Patient's Relationship to Guarantor: Child Spouse Other:
Address (if different):	Birth date:	Social Security #:

INSURANCE INFORMATION:

Primary Insurance Company Name:	Plan Name:	Type of Plan: PPO POS HMO Medicaid Medicare Tricare Medicare HMO WC Lien	
Claims Address:			Phone#:
Policy#:	Group #:	Group Name:	
COPAY:	Annual Deductible: Met Not Met Don't Know	Coinsurance: None (Plan pays 100%) 70/30 80/20 90/10 Don't Know	Effective Date:
Is plan thru employer? No Yes	Employer address:		Occupation:
Secondary Insurance Company Name:	Plan Name:	Type of Plan: Medicare Supplemental Medicaid Other Employer/Commercial Spouse's Plan (Pls. complete guarantor section) Other:	
Claims Address:			Phone#:
Policy#:	Group #:	Group Name:	
Is plan thru employer? No Yes	Employer Name & Address:		

ACKNOWLEDGEMENT:

The above information is true to the best of my knowledge. I consent to the use and disclosure of my protected health information for treatment, payment and health care operations as described in this clinic's Notice of Privacy Practices. I authorize my insurance benefits be paid directly to XXXX as indicated on the claim. I understand that I am financially responsible for all fees and balances, regardless of insurance coverage.

Patient/Guardian signature: ______________________ Date ______________

161 LINCOLN HWY., UNIT-A, EDISON, NJ 08837, TEL: 732.902.2700, FAX: 949.862.7791

Healing HandZ Physical Therapy

Financial Policy

Effective June 1, 2016 **Patient Name:______________________________**

Thank you for choosing HEALING HANDZ PHYSICAL THERAPY as your health care provider. **Please carefully read and initial by each statement and sign below.** This policy has been put in place to ensure that financial payments due are recovered to allow us to continue to provide quality medical care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our practice manager or billing department will be glad to discuss these policies with you.

1. _______ I understand that if I do not have my insurance card, referral, and / or co-payments, that my appointment may be rescheduled until such time that I can provide the required documents or payments.
2. ______ I understand that HEALING HANDZ PHYSICAL THERAPY will collect all copayments at the time of visit and any procedure deductibles and coinsurance up to an amount equal to payment in full for the planned procedure code. Payment in full and expected coinsurance payment responsibility are determined by the anticipated billing code(s), details of your insurance policy, and agreement between your insurance company and HEALING HANDZ PHYSICAL THERAPY. Any overpayment to your account will be refunded to you at your request <u>after</u> payment and/or remittance has been received from your insurance company.
3. _______ I understand that a $25 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. NSF checks must be redeemed with certified funds (cashier's check, money order, or cash.)
4. _______ I understand that if I am unable to make a scheduled appointment I need to contact HEALING HANDZ PHYSICAL THERAPY at least 24 hours before my scheduled appointment time. Due to a high demand for appointments, missed appointments prevent us from scheduling appropriately and keep others in need of urgent care from being seen. A $25 FEE WILL BE ASSESSED FOR ALL MISSED APPOINTMENTS NOT CANCELED WITH AT LEAST 24-HOUR ADVANCED NOTICE, AND & $50 FOR NO-SHOWS & MISSED/CANCELLED SATURDAY APPOINTMENTS.
5. ______ I understand that if my account is not paid in full within 90 days of a statement date, a 35% collection agency processing fee will be added to the outstanding balance and will be turned over to collections for further processing. No additional appointments will be made for delinquent accounts until they are brought current.
6. ______ HEALING HANDZ PHYSICAL THERAPY will allow 60 days from the date of filing for my insurance company to process or pay a claim. State law allows insurance companies operating in the state no more than 60 days to process claims. It is my responsibility to provide my insurance company with requested information needed to process a claim for services. It is also my responsibility to notify HEALING HANDZ PHYSICAL THERAPY if there is any change in my insurance coverage, residence, or phone number. <u>ULTIMATELY, IT IS UP TO ME TO KNOW MY INSURANCE BENEFITS.</u>

I have read and agree to all the provisions of the above financial policy. I understand that I am ultimately responsible for all professional fees incurred for professional services performed by the attending therapist/physician.

Signature of Responsible Party:____ Date:______________

ASSIGNMENT OF BENEFITS

We require insured patients to complete assignment of benefits authorizing insurance to remit payment to physician's office.

I hereby assign all medical and /or surgical benefits to include major medical benefits to which I am entitled, private insurance, and any other health plans to: HEALING HANDZ PHYSICAL THERAPY. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges where or not paid by said insurance. I hereby authorize said assignee to release all medical information necessary to secure the payment.

Signature of Responsible Party:____ Date:______________

Consent to Treat/Release of Information

CONSENT TO EVALUATE AND TREAT I do hereby consent to the evaluation and treatment by Healing HandZ Physical Therapy. I understand that it is my right to accept or refuse any treatment offered me. I acknowledge and understand that no guarantee has been made to me as to the results that may be obtained from such treatment.

RELEASE OF INFORMATION I authorize Healing HandZ Physical Therapy to release information from my medical record, whether it be written, video, photographic, audio or verbal, to my physician and/or any third party payor (such as insurance company or governmental agency) for its use in processing claims for payment. I understand the nature of the authorization and have been informed that I have the right to revoke consent at any time by written communication with custodians of records. I consent to the release of medical information to ____ for communication and care coordination on by behalf.

PRIVACY PRACTICES I acknowledge receipt of the Healing HandZ Notice of Privacy Practice, which I have received at the time of this initial visit or previously.

ASSIGNMENT OF BENEFITS I request that payment of Medicare and/or other insurance benefits be made on my behalf to Healing HandZ Physical Therapy Associates for any services furnished to by Healing HandZ Physical Therapy.

FINANCIAL AGREEMENT The undersigned agrees, whether signing as agent or patient, that s/he individually obligates her/himself to pay for services rendered in accordance with the regular rates and terms of Healing HandZ Physical Therapy Associates. Healing HandZ will verify insurance benefits on behalf of the patient. Verification is no guarantee of payment. The agent/patient is responsible for any co-payment, deductible, coinsurance and all amounts identified by the insurer as the patient's responsibility.

SECONDARY INSURANCE COVERAGE I understand that if I fail to disclose any secondary insurance coverage at the time of this signing or after the first service date when said insurance became effective, I can be held responsible for any balances indicated by my primary coverage. This includes balances due to lack of authorization for secondary services.

- I do not have secondary coverage to my Medicare or Auto Coverage
- I choose not to use my secondary coverage after Medicare or Auto processes the claim.

HOME HEALTHCARE As a Medicare beneficiary, I am aware that I can not receive physical therapy through an independent clinic if I am currently enrolled with a Home Healthcare Agency. If services were provided and I was not formally discharged by the agency, I realize that I will be held responsible for services denied by Medicare. Name of Home Healthcare Agency ______________________________ Date of Discharge:_________________

The undersigned certifies that s/he has read, understood and accepts the terms of this form, received a copy, and is the patient or is duly authorized by the patient as the patient's general agent to execute this form.

______________________________________ ______________________________
Signature of Patient or Responsible Party Date

______________________________________ ______________________________
Witness Date