Prime Health
PHYSICAL THERAPY, INC
"When Health is Your First Priority"

Email : info@primehealthpt.com
Website : www.primehealthpt.com

OFFICE POLICY & PROCEDURES

Welcome to Prime Health Physical Therapy. We appreciate your confidence and trust in our professional services. We are dedicated to the quality care of all patients and are always here to discuss your problems and together find the best solution.

Please carefully read and initial each line of our office policies listed below:

_____ Co-payments or payments are due at the time of service. Payments can be made via credit card, personal check, or cash.

_____ You are responsible for obtaining a Primary Care Physician referral or prescription if required by your insurance company. No visits will be back-dated for any reason.

_____ We file all insurance claims for you. In most cases, insurance companies will make payment to our office directly. If you receive payment for our services, you are responsible to bring the checks to our office no later than 30 days after being issued to you.

_____ Please remember to make appointments and set aside time for each treatment session. In the event you are running late or need to reschedule appointments, **we expect at least 24-hour's notice. If we receive less than 24-hour's notice or you do not show up for your appointment (other than emergencies), your account will be charged a $25 fee.**

If at any time you are experiencing a problem regarding billing and payment, please do not hesitate to contact our office and we will be happy to assist you and answer your questions.

After you have carefully read the above, please sign the following:

I _____, agree to be treated by Prime Health Physical Therapy and its staff. I have read and understand all the terms specified above.

Signature: _____ Today's Date: _____

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PATIENT INFORMATION (Please Print)

Date: _____

First Name: _____ Middle Initial: ____ Last Name:_____

Gender: M / F Marital Status: M / S / D / W DOB: _____SS# _____

Address: _____ City: _____ State: _____ Zip:_____

Home Phone: _____ Cell Phone: _____

Email Address: _____ **Height:** _____Ft. _____ Inches

Employer: _____ Weight_____ Pounds

Position: _____ **Auto Related Injury**: Y / N

Primary Care Physician: _____ **Work Related Injury:** Y / N

Physician Date Last Seen:_____ Date of Injury: _____

Phone #: _____

How did you hear about us? (Please circle one) Doctor / Family / Friend / INS / Walk In / Other

If other, please explain:_____

Have you received Physical Therapy before? Y / N

If yes, when? _____

Emergency Contact Information

Name: _____

Relationship to Patient: _____

Phone #: _____

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MEDICAL HISTORY

Name:_____ Date: _____

□ Allergies	□ Cerebral Palsy	□ Diabetes	□ Pacemaker
□ Anemia	□ COPD	□ Hypoglycemia	□ Cerebral Palsy
□ Arthritis	□ CVA (Stroke)	□ Kidney Diseas	□ Psychological Disorder
□ Lupus	□ Hearing Loss	□ Liver Disease	□ Seizure Disorder
□ Cardiac (MI, Arrhythmia, Angina)		□ Thyroid (Hyper, Hypo)	□ Osteoporosis, Osteopenia
□ Cancer	□ Multiple Sclerosis	□ Visual Loss	□ Parkinson's
□ HIV/AIDS	□ High Cholesterol	□ High Blood Pressure	□ Other:_____

Past Surgeries / Hospitalizations (if any): _____

_____

Have you ever broken any bones? Y / N If yes, where: _____

Past motor vehicle accidents? Y / N If yes, explain: _____

Are you taking any medications? Y / N If yes, please list: _____

_____

Do you have any metal implants? Y / N If yes, where? _____

Are you, or do you think you may be pregnant? Y / N If yes, how many months? _____

Do you have children? Y / N Ages: _____

Do you smoke? Y / N If yes, when did you start? _____

What sports/recreational activities do you participate in? _____

Dominant Side of the Body? Right / Left

Briefly describe your present problem: _____

_____

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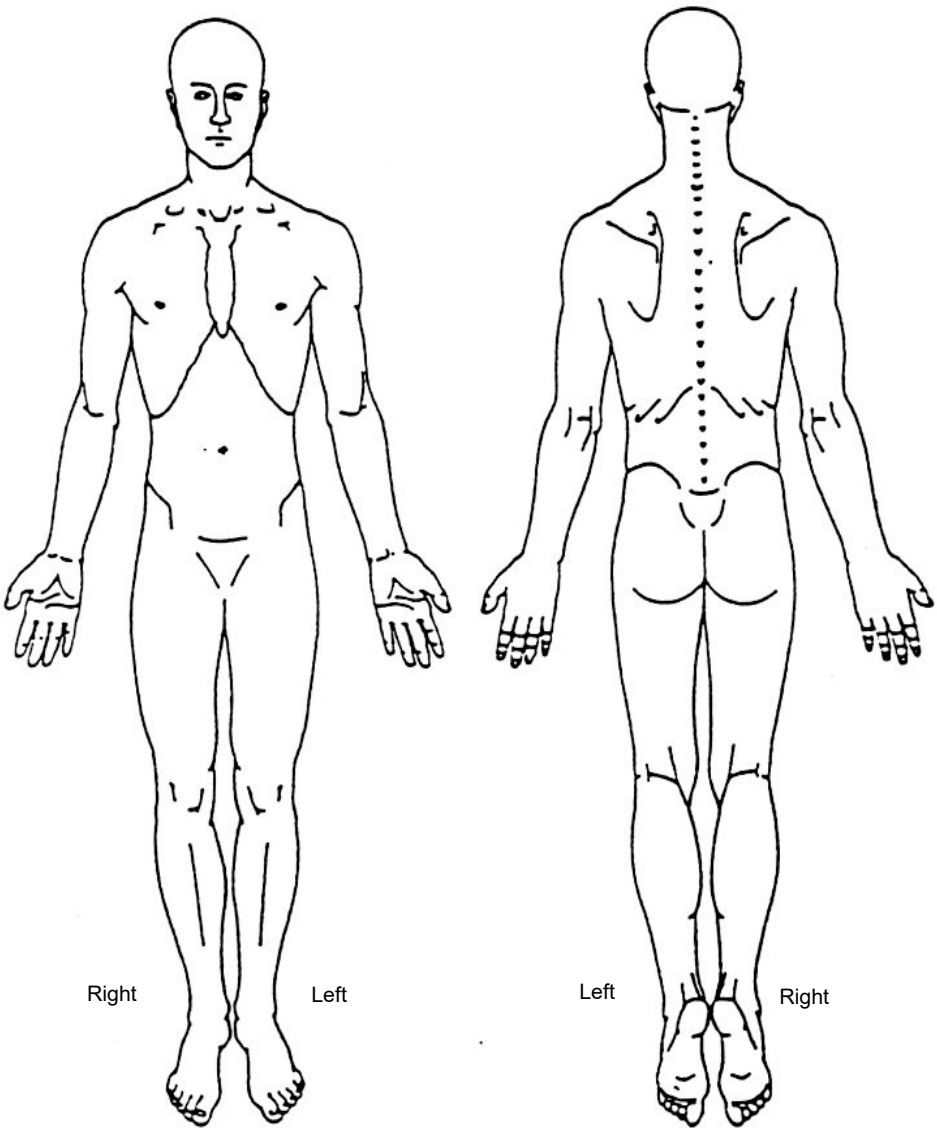
Name: _____ Date: _____

Note the location of your pain on these drawings. (If the back of your neck is painful, mark the drawing on the back of the neck, etc.) If you feel any of the following symptoms, please indicate where you feel them by placing the symbols on the diagrams and checking the frequency of your pain.

Numbness: ========	Burning: xxxxxxxxx	□ CONSTANT
Pins and Needles: //////////	Aching: ^^^^^^^^^^	□ PERIODIC
Radiating:	Stabbing: 0000000	□ BRIEF



822 N. Wood Ave, Ste 3, **LINDEN**, NJ 07036 **P: 908-925–9700** F: 908-663-2551

1907 Oak Tree Rd, Ste 203, **EDISON**, NJ 08820 **P: 732-283-2500** F: 732-358-2350

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INSURANCE INFORMATION

Primary Insurance: _____ Member ID #: _____

Provider Phone #: _____ Group #: _____

Copay Amount: _____ Deductible: _____

AUTHORIZATION TO RELEASE INFORMATION OF BENEFITS

I hereby authorize Prime Health Physical Therapy to apply for benefits on my behalf for covered services render by the Practice order. I request that payment from my insurance be made directly to Prime Health Physical Therapy. I authorize release of any medical information necessary to process this claim. I permit a copy of this assignment to be used in place of the original. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for any balance not covered by my insurance company.

Signature: _____ Today's Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, hereby acknowledge that Prime Health Physical Therapy has provided me with a copy if its Notice of Privacy Practices that described how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have any questions or complaints, I may contact: Prime Health Physical Therapy at 908- 925-9700.

I also understand that I am entitled to receive updates upon request if Prime Health Physical Therapy amends or changes its Notice of Privacy Practices in a material way.

Signature: _____ Relationship to Patient: _____

Date: _____

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ASSIGNMENT OF BENEFITS FORM

Patient Name: _____

I irrevocably assign to Prime Health Physical Therapy Incorporation all my rights and benefits under any insurance contracts for payment for services rendered to me by Prime health physical therapy. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by Prime health physical therapy to be released to Prime health physical therapy. I irrevocably authorize Prime health physical therapy to file insurance claims on my behalf for services rendered to me. I irrevocably direct that all such payments go directly to Prime health physical therapy. I irrevocably authorize Prime health physical therapy to act in my behalf and report any suspected violations of proper claims practices to the proper regulatory authorities. I understand that whatever amounts you do not collect from insurance company proceeds, whether it is be all or part of what is due, I will personally owe you.

This assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect.

Patient signature: _____ Date: _____

RECORDS RELEASE AUTHORITY

To:_____

I, _____ hereby request that you release to:

Prime Health Physical Therapy, Inc.,
822 N. Wood Avenue, Suite 3,
Linden, NJ 07036
Phone: (908) 925-9700
Fax: (908) 663-2551

A report of my diagnosis, treatment, prognosis, recommendations, any diagnostic test results, MRI, radiographic reports as well as other data pertinent to your treatment of me from_____ to _____

_____	_____	_____
Patient's name	Patient's signature	Date

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Patient Financial Responsibility Consent Form

Please read carefully this important information about your responsibility for payment for your care and services. The providers of PHPT are participating providers with most insurance companies. However, our list of accepted insurances is subject to change at any time and not all plans under all companies are accepted. In order to avoid unexpected charges, please confirm that your particular health benefit plan is accepted by PHPT. You should reach out to your carrier when you initiate care here to familiarize yourself with the limits of your policy and what will and will not provide coverage for. We do our best to guide patients through this process, but ultimately it is impossible for us to keep abreast of the requirements in the thousands of insurance products on the market. It is an individual patient responsibility to understand the provisions, limits, and requirements of their individual benefit plan(s) and advise us accordingly.

Please be aware that, except as contractually agreed otherwise by PHPT, patients are ultimately responsible for insuring payment for all medical services provided. If a carrier denies payment for services because a plan requirement was not met, services were considered “non-covered”, the plan benefits were exceeded, care is considered medically unnecessary, or treatment is considered experimental, among other reasons, patients will be held accountable for those charges. Although PHPT will often submit a claim to insurance for our patients, if your insurance requires you to pay a co-payment and or deductible, you will be required to pay that portion of the cost at the time of service. We will ask you for payment at the time of check in and registration at the front desk. If you do not pay your co-payment at the time of service, we will bill you for this, along with a billing fee to offset the cost of sending the statement.

If you have a secondary insurance and provide us with that information during the initial visit, as a courtesy we will bill the secondary insurance. It is not a guarantee that we will get paid by the secondary insurance and it is ultimately your responsibility to make sure that all of your financial obligations are met as part of services we provided. Please bring your insurance card with you each visit and notify our staff of any changes in your coverage. All patient accounts are to be paid at the time of service. We will ask you for payment on any outstanding balances. Prime Health Physical Therapy accepts cash, checks and major credit cards. Checks that are returned to PHPT unpaid from your account will be assessed an additional $25 NSF fee. Financial problems should not be a deterrent to obtaining medical care. If you require special arrangements, please contact our patient care coordinator prior to your appointment for a private consultation.

PATIENT WITHOUT INSURANCE: As a courtesy for patients who do not have health insurance coverage, PHPT has created a tiered self-pay fee schedule which includes a percentage discount from our normal fees. Patient who have no insurance and pay in full at the time of service will receive the maximum discount. Patients who have no insurance and pay at least 50% of their balance receive a smaller discount. If you are interested in knowing an estimate of our fees for services rendered, please contact one of our staff members.

The providers and staff at Prime Health Physical Therapy are committed to excellence in customer service and quality care of our patients. Feel free to contact our office for questions or concerns regarding your financial health insurance issues.

Patient Signature _____ Date Signed _____

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TO OUR PATIENTS REGARDING CANCELLATION AND NO-SHOWS

The following are our policies regarding cancellation and no-shows. We take this subject very seriously at our facility because it can make significant difference whether you succeed in your treatment or not. Usually your referring Doctor and/or your Therapist have prescribed a set frequency of treatment. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is to follow your therapist's instructions and we will be able to help you achieve your goals in treatment.

We require at least 24 hours' notice in the event of a cancellation. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get the full prescribed number of treatments that week whenever possible. All patients that do not cancel within this period are subject to $25.00 late cancellation fee. This charge will not be covered by insurance but will have to be paid by you personally before being seen on your next visit.

We see our patient's according to their respective schedules. In the event you are late by more than 10 minutes of your scheduled appointment time, you will be listed as a No Show and will need to reschedule your appointments. At the discretion of the office, we may also try to accommodate you if and when we can provide our service reasonably without affecting any of our scheduled patients.

If a patient cancels or no-shows for three consecutive appointments, the patient will not be re-scheduled again until they speak to the clinical administrator. As a courtesy, the office may try to contact the patient to decide if the patient can return to the facility. The clinic reserves the right to discharge the patient at the sole discretion of the administrator in the event of above occurrences.

For Worker's Compensation and Personal Injury patient's documentation of any missed/canceled appointments is forwarded to your Case Manager and or referring physician and this may adversely affect your claim.

Please be aware that your pain will probably increase and decrease as your course of treatment progresses and before it is finally alleviated. Either condition can seem to be a reason not to come in;

a) You are feeling worse and think the treatment is not working or
b) You are feeling better and it is a great day for wind surfing

Neither of these conditions is legitimate as a reason not to come:

a) If you are in pain, come in and get it fixed, and
b) If you are out of pain, now is the time when we can begin doing some real correction of the underlying causes of your problem and educate you so you won't re-injure yourself, etc.

When you don't show up as scheduled, three people are hurt: (1) YOU because you don't get the treatment you need as prescribed by the Doctor and or Therapist; (2) the THERAPIST now has a space in their schedule since the time was reserved for you personally; and (3) ANOTHER PATIENT who could have been scheduled for treatment if you had given proper notice.

We are looking forward to your sincere co-operation in this regard. We are looking forward to work with you to achieve your goals.

_____ _____

Patient Signature: Date: