FYZICAL Therapy & Balance Centers

498 Inman Ave. Suite 200, Colonia, NJ 07067

Name:_____ DOB:_____ Sex: M F

Telephone #:_____SSN: _____

Address: _____ City:_____State: _____ Zip: _____

Email:_____ Height:_____ Weight:_____ Shoe size: _____

Employer Name:_____Employer Phone:_____Employer City:_____

Occupation:_____ How did you hear about us? _____

Primary Care Physician:_____Telephone#: _____

Address:_____City:_____State:_____

Primary Insurance Policy Holder Name & DOB (if different) _____

Primary Insurance Policy Holder SS# (if different)_____Relationship to patient:_____

Secondary Insurance Policy Holder Name & DOB (if different)_____

Secondary insurance Policy Holder SS# (if different)_____Relationship to patient:_____

Attorney name:_____ Telephone#_____

Emergency Contact Name :_____Phone #_____

Relationship to patient: _____

Worker's Compensation Patients Only:

Was accident with present employer? **Y** **N** If not, then who was your employer at the time?_____

Employer Name:_____ Employer Phone#:_____

Date of injury:_____ Employment Status: FT PT Self Retired Student

Claim#:_____ Adjuster name : _____

Adjuster phone#:_____ Adjuster fax #_____

Motor Vehicle Accident Patients Only:

Date of accident:_____Claim#:_____Adjuster name:_____

Adjuster phone#:_____Adjuster fax #:_____

Which insurance is considered Primary for this accident? **MEDICAL** **AUTO**

I authorize FYZICAL Therapy & Balance Center of Colonia to treat me and to release to my insurance company/lawyer/employer any information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating claims for benefits.

Patient signature:_____ **Date**:_____

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CONSENT OF TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorizeFYZICAL THERAPY & BALANCE CENTER of Colonia through its appropriate personnel, to furnish medical care and treatment to me, or the above named patient, considered necessary and proper in diagnosing or treating my/his/her physical condition.

I further authorize FYZICAL THERAPY & BALANCE CENTER of Colonia to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment necessary to secure payment for services provided.

I understand that the objectives of Physical Therapy treatment are to relieve my pain and increase my functional ability. While it is expected that we will meet our objectives, I also understand that with a condition like mine there is no guarantee. I am entering into this program hopeful yet with the full understanding that my expectations may not be met.

I agree that any dispute shall be resolved by binding arbitration under the rules of the American Arbitration Association. The word of the arbitrator(s) shall be final and binding upon both parties. A demand for arbitration must be in writing and must be made by the aggrieved party.

Signature:_____ **Date:**_____

Relationship to patient: Self Guardian Other:_____

CONSENT TO REPRESENTATION IN APPEALS AND ARBITRATION OF CLAIMS

I agree to representation by FYZICAL THERAPY & BALANCE CENTER of Colonia in an appeal of an adverse utilization management determination as allowed by NISA 26:2S-11, and release of personal health information to the NJ Dept. of Banking and Insurance (DOBI), its contractors for the Independent Health Care Appeals Program, and independent contractors reviewing the appeal. My consent to representation and authorization of release of information expires in 24 months, but I may revoke both sooner. I also agree to the release of personal health information to DOBI, its contractor for the Independent Claims Arbitration Program, and any independent contractors that may be required to perform the arbitration process. My authorization of release of information for purposes of claims arbitration will expire in 24 months.

Signature:_____ **Date:**_____

Relationship to patient: Self Guardian Other:_____

PHOTO/VIDEO RELEASE

I hereby DO / DO NOT grant and authorize FYZICAL THERAPY AND BALANCE CENTER of Colonia the right to take, edit, alter, copy , exhibit, publish, distribute and make use of any or all pictures of videos taken of me to be used in and/or for legally promotional materials including but not limited to , websites, and social media networks such as Instagram, Facebook, and Tiktok without payment or any other consideration. This authorization extends to all languages, media , formats, and markets now known or hereafter devised. This authorization shall continue indefinitely unless I revoke said authorization in writing.

Name:_____

Signature:_____ **Date**:_____

498 Inman Ave. Suite 200, Colonia, NJ 07067

Statement of Financial Responsibility

Patient Name:_____ **Date**:_____

FYZICAL THERAPY & BALANCE CENTER of Colonia appreciates the confidence you have shown in choosing us to provide for your rehabilitative needs. The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, we are not responsible for errors and you are ultimately responsible for the payment of your bill.

You are responsible for payment of any co-payment at the time of service and on receipt of a bill for any deductible/coinsurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you and your physician elect to continue therapy past your approved periods, you will be responsible for your account balance in full. You are responsible for paying any type of collection fee that occurs as a result of your account being forwarded to a collection agency. For your convenience, we accept cash, checks and most major credit cards. Payment is accepted by payment due date on your monthly patient statement. Payments can be made in the office or mailed to the address on your statement.

I have read the above policy regarding my financial responsibility to FYZICAL THERAPY & BALANCE CENTER of Colonia for providing rehabilitative services to the above named patient or me. I certify that the information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to FYZICAL THERAPY & BALANCE CENTER of Colonia. I agree to pay FYZICAL THERAPY & BALANCE CENTER of Colonia the full and entire amount of all bills incurred by me or the above named patient, if applicable, any amount due after payment has been made by my insurance carrier, as well as any type of collection fee that occurs as a result of your account being forwarded to a collection agency. I understand I am financially responsible to FYZICAL THERAPY & BALANCE CENTER of Colonia for charges not covered by the authorization.

Signature:_____**Date**:_____

BILLING DISCLOSURES TO INDIVIDUALS INVOLVED IN PATIENT'S CARE

There may be times when it is necessary for an individual directly involved in your care to call the facility to inquire about your personal health information or billing information. Please take a few moments to complete this section. I authorize FYZICAL THERAPY & BALANCE CENTER of Colonia to disclose my health information that is directly related to my current treatment at FYZICAL THERAPY & BALANCE CENTER of Colonia to the individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received.
Such persons involved in your care may include: spouse, children, blood relatives, roommates, boyfriends/girlfriends, domestic partners, neighbors and colleagues.

NAME:_____ **RELATIONSHIP**:_____

Signature:_____ **Date**:_____

(Relationship to patient self—guardian—other:_____)

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HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

FYZICAL THERAPY & BALANCE CENTER of Colonia

a) Is required by law to maintain privacy of your protected health information (PHI) and to provide you with a copy of this Privacy Notice detailing FYZICAL THERAPY & BALANCE CENTER of Colonia legal duties and privacy practices with respect to your PHI.

b) May be required by State law to maintain greater restrictions on the use or release of your PHI than that which is provided under federal law. FYZICAL THERAPY & BALANCE CENTER of Colonia is required to and will comply with all required State statutes.

c) Is required to abide by the terms of this Privacy Notice and will distribute any revised Privacy Notice to you prior to implementation.

d) Reserves the right to change the terms of this Privacy Notice to make the new Privacy Notice provisions effective for your entire PHI that it maintains.

e) Will comply with our complaint policy and will not retaliate against you for filing a complaint.

By signing my name below, I acknowledge that I have read and understood the Privacy Notice. Furthermore, I give FYZICAL THERAPY & BALANCE CENTER of Coloniathe expressed written consent to display my name in any "In-Office" usages, including but not limited to sing-in sheet, files, charts, mobile devices, and e-mail. I also understand that if my name is requested to be used for promotional purposes outside of the office, a separate acknowledgement of permission will be made in writing.

Signature:_____ **Date:**_____

Relationship to patient: Self Guardian Other:_____

CANCELLATION POLICY

FYZICAL THERAPY & BALANCE of Colonia requests 24 hours notice upon canceling an appointment. If prior notice is not given, you will be charged $75 for the missed appointment. Each physical therapy session is customized for the individual. We are committed to you 100% and expect your commitment in return. Signing this agreement confirms your consent to these terms.

Name:_____

Signature:_____ **Date**:_____

FYZICAL® Therapy & Balance Centers

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MEDICATION LIST

Patient Name:_____ **Date:**_____

MEDICATION	DOSAGE	FORM	ADMINISTRATION	FREQUENCY

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You are responsible for payment of any co-payment at the time of service and on receipt of a bill for any deductible/coinsurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you and your physician elect to continue therapy past your approved periods, you will be responsible for your account balance in full. You are responsible for paying any type of collection fee that occurs as a result of your account being forwarded to a collection agency. For your convenience, we accept cash, checks and most major credit cards. Payment is accepted by payment due date on your monthly patient statement. Payments can be made in the office or mailed to the address on your statement.

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