FYZICAL Therapy & Balance Centers

498 Inman Ave. Suite #200
Colonia, NJ, 07067
732-587-5656

Name: _____ DOB: _____

Sex: M F Telephone #: _____ SSN: _____

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

Email: _____ Height: _____ Weight: _____ Shoe Size: _____

Primary Care Physician: _____ Telephone #: _____

Address: _____ City: _____ State: _____

Occupation: _____ How did you hear about us? _____

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#: _____

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 #: _____

Emergency Contact Name: _____ Phone #: _____

Relationship to patient: _____

I authorize FYZICAL Therapy & Balance Centers in Colonia NJ 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 authorize FYZICAL Therapy & Balance Centers in Colonia NJ 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 Centers in Colonia NJ 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 increased 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 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 Centers in Colonia NJ 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 contactor 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: _____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

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 Centers in Colonia, NJ 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 Centers in Colonia, NJ 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 Thomas DiPaolo, PT, DPT the 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: _____

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Statement of Financial Responsibility

Patient Name: _____ Date: _____

FYZICAL Therapy & Balance Centers in Colonia NJ 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, 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 and 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 Centers in Colonia NJ 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 Centers in Colonia NJ. I agree to pay FYZICAL Therapy & Balance Centers in Colonia NJ the full and entire amount of all bills incurred by me or the above name 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 Centers in Colonia NJ 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 Centers in Colonia NJ to disclose my health information that is directly related to my current treatment at FYZICAL Therapy & Balance Centers in Colonia NJ 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: _____

Dear Patient:

FYZICAL Therapy & Balance Centers in Colonia NJ would like to welcome you to our facility and thank you for choosing us to participate in your care. This letter is to remind you that you may receive insurance checks from your insurance company along with an Explanation of Benefits (EOB) for the services rendered in this office.

Please DO NOT cash these checks. Please endorse the back of the checks and write "Pay to FYZICAL Therapy & Balance Centers in Colonia NJ, Deposit Only" below your signature. Next, either bring the check AND the EOB to the office or mail them directly to FYZICAL Therapy & Balance Centers in Colonia NJ, 498 Inman Ave. Suite #200 Colonia, NJ, 07067, as soon as you receive it. It is very important that you attach all of the paperwork with the checks so we can credit your account correctly, otherwise you risk your account being forwarded to collections.

Should you have any questions regarding the above, please feel free to contact me directly at (732) 587-5656. We look forward to working with you.

With Appreciation,

Dr. Thomas DiPaolo, PT ,DPT

Signature: _____ Date: _____

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Medication List

Name of Medication	Dosage	Form (Pill, Liquid, Powder)	Route of Administration (by mouth, syringe, etc.)	Frequency

Please ask the front desk if another Medication List is needed.