

PATIENT REGISTRATION FORM

(Kindly print)

Name: _____ Date: _____
First Middle Last

Address: _____

Home #: _____ Work #: _____ Cell #: _____

Email: _____

Date of Birth: _____ Sex: _____ Marital Status: _____

Social Security# _____ Age: _____

Occupation: _____ Employer: _____

Emergency Contact's name and phone: _____

Can we release medical info to this person? Y N

Referring Physician/Person: _____

Primary Care Physician: _____ Phone# _____

Have you received physical therapy this year? Y N

If yes, at what facility and for approximately how long? _____

Does the patient live at the primary insured address Y N

If No, please provide address and phone #of primary insured:

_____ Phone# _____

Insurance information:

Primary Insurance: _____ ID and Group #: _____

Subscriber: _____ Relationship: _____

Subscriber's DOB: _____ Subscriber's SS# (*required*) _____

Copay/Coinsurance: _____ Initial: _____

Secondary Insurance: _____ ID and Group #: _____
Subscriber: _____ Relationship: _____
Subscriber's DOB: _____ Subscriber's SS# (required) _____
Copoly/Coinsurance: _____ Initial: _____

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If this is due to a work related injury, please complete the following:

Employer: _____ Date of accident: _____
Employer address: _____
Claim # _____
Case Manager/contact person: _____ Phone# _____

If this is due to a Motor Vehicle Accident, please complete the following:

Insurance company: _____ Claim#: _____
Insurance address: _____ Phone# _____
Case Manager/Contact Person: _____ Date of accident: _____
Attorney (if applicable): _____ Phone# _____

Are you receiving Chiropractic Care Y / N

If you are receiving Chiropractic care please schedule your physical therapy appointments on separate days. Motor Vehicle insurance does NOT allow for a person to have Chiropractic and Physical Therapy services on the same day. Thank You

MEDICAL HISTORY FORM

Name: _____

Date: _____

DOB: _____

Sex: M F

Chief complaint /What brought you here?:

Allergies: _____

Pregnant: Y N

X-Rays: Y N result _____

MRI: Y N result _____

EMG/NCV: Y N result _____

Other tests: _____

What have you done to treat this condition on your own? _____

Past Medical History:

Heart Disease: Y N

Lung Disease: Y N

Kidney Disease: Y N

Asthma: Y N

Bleeding problems: Y N

Diabetes: Y N

High Blood Pressure: Y N

Cancer: Y N

Stroke/TIA: Y N

Seizures/Epilepsy: Y N

DVT Y N

HIV/AIDS Y N

Latex Allergy Y N

Adhesive Allergy Y N

High Cholesterol Y N

Osteoporosis Y N

Past Surgical History:

Surgery: _____

Date: _____

Surgery: _____

Date: _____

Medications:

_____ see attached list(please provide a list to copy if checking this line)

CONSENT FOR TREATMENT AND ASSIGNMENT OF BENEFITS

Insurance Customers:

I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist, and/or physician may be considered necessary or advisable while a patient at Joint Motion, L.L.C. Physical Therapy. I consent to the use of my otherwise protected health information for my treatment, Joint Motion practice operations, and to secure insurance reimbursement. I understand that I will be treated in an open air environment and limited personal information may be unavoidable disclosed. I request that payment of authorized benefits be made on my behalf to:

Joint Motion, L.L.C.
403 Park Ave
Scotch Plains, NJ 07076

For any services furnished me by Joint Motion, L.L.C. Physical Therapy. I authorize any holder of medical information about me to release to my insurance company(ies) and its agents any benefits payable for related services. I hereby authorize my insurance company(ies) to furnish to the above named therapist any information regarding my insurance claims under Title XVIII of the Social Security Act. I also am aware that I may be responsible for any charges that my insurance company denies payment for service as “not medically necessary.” A copy of this signature is as valid as the original.

Signature: _____

Witness: _____

Date: _____

Self Pay Customers only:

Name of Patient: _____

This is to certify that I am financially responsible to Joint Motion, LLC for services rendered to me. I also authorize payment directly to Joint Motion, L.L.C. benefits otherwise payable to me but that do not exceed the charges stated.

Signature: _____

Witness: _____

Date: _____

NOTICE OF PRIVACY PRACTICES FOR JOINT MOTION, L.L.C.

Upon each physical therapy visit, a patient's record is made. This record contains your health history, current symptoms, examination, results, diagnoses, treatment and plan for future care or treatment. This information often referred to as your medical record serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third party payer can verify that you actually received the services billed for

Understanding what is in your health records and how your health information is used helps you to:

- Ensure its accuracy and completeness
- Understand who, what, where, why and how others may access your health information
- Make informed decision about authorizing disclosure to others

Although your health records are the physical property of the health care provider who completed it, you have certain rights with regard to the information contained therein. You have the right to

- Request restriction on uses and disclosures of your health information for treatment, payment and health care operations. Health care operations consist of activities that are necessary to carry out the operations of the provider, such as quality assurance and peer review.
- Obtain a copy of this notice of information practices. You have a right to a hardcopy upon request.
- Inspect and copy your health information upon request. Again, this right is not absolute. In certain situations, such as if access would cause harm, we can deny access. You do not have a right of access to the following:
 - Information compiled in reasonable anticipation of or for use in civil, criminal, or administrative actions or proceedings.
 - Information was obtained from someone other than a healthcare provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of information.
 - In other situations, the provider may deny you access but, if it does, the provider must provide you with a review of the decisions denying access. These "reviewable" grounds for denial include:
 - Licensed health care professional has determined, in the exercise of professional judgment, that the access is reasonably likely to endanger the life or physical safety of the individual or another person.
 - For these reviewable grounds, another licensed professional must review the decision of the provider denying access within 60 days. If we deny you access, we will explain why and what your rights are, including how to seek review.

We reserve the right to charge a reasonable, cost-based fee for making copies

Our Responsibilities under the Federal Privacy Standard

In addition to providing you your rights, as detailed above, the federal privacy standard requires us to:

- Maintain the privacy of your health information, including implementing reasonable and appropriate physical, administrative, and technical safeguards to protect the information.
- Abide by the terms of this notice
- Train our personnel concerning privacy and confidentiality.

WE RESERVE THE RIGHT TO CHANGE OUR PRACTICES AND TO MAKE THE NEW PROVISIONS EFFECTIVE FOR ALL INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION WE MAINTAIN. SHOULD WE CHANGE OUR INFORMATION PRACTICES, WE WILL MAIL A REVISED NOTICE TO THE ADDRESS YOU HAVE SUPPLIED US.

We will not use or disclose your health information without your consent or authorization, except as described in this notice or otherwise required by law.

How to get more information or to report a problem

If you have questions and/or would like additional information, you may contact the office by phone at (908)322-3202.

Examples of Disclosures for treatment, payment and health operations

If you give us consent, we will use your health information for treatment.

Example: A physical therapist will record information in your record to diagnose your condition and determine the best course of treatment for you.

If you give us consent, we will use your health information for payment.

Example: We may send a bill to you or a third-party payer, such as a health insurer. The information on or accompanying the bill may include information that identifies your diagnosis, treatment received, and supplies used.

If you give us consent, we will use your health information for health operations.

Examples:

Business Associates: We provide some service through contracts with business associates. An example of this is a collection agency. When we use these services, we may disclose your health information to the business associate so that they can perform the function(s) we have contracted with them to do and bill you or your third party payer for services rendered. To protect your health information, however, we require the business associates to appropriately safeguard your information.

Workers Compensation: We may disclose health information to workers compensation carriers

Law Enforcement: We may disclose health information to a valid subpoena.

The federal Department of Health and Human Services (DHHS): Under the privacy standards, we must disclose your health information to DHHS as necessary for them to determine our compliance with those standards.

Phone Calls: We may disclose information over the answering machine and/or with someone answering the phone regarding confirming/changing your appointment or asking for any information needed regarding your insurance.

ACKNOWLEDGEMENT OF RECEIPT OR PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. You have the right to review our Notice and ask questions about our privacy practices. The terms of our notice may change. Upon request a copy of our revised notice will be made available to you.

By signing this form you acknowledge that you have received our Notice of Privacy Practices.

Name of Patient

Signature of Patient