JointCare
Physical Therapy
& Fitness Center

CHECKLIST FOR YOUR FIRST VISIT

You're ready for your first visit when you have the following:

- ☐ **Medical Prescription (Not required however recommended for post operative patients)**
- ☐ **Referral from primary care physician (If required, our office staff will contact you prior to your Initial Evaluation)**
  - A medical prescription is a script written from the doctor prescribing the services needed, like the slip given to the pharmacist when filling a prescription for medication
  - A referral is different. This is an insurance company form filled out by and obtained from your primary care physician's office that allows you to be seen, so services will be reimbursed and not denied upon claim submission. If you are not sure you need one, ask our staff.
- ☐ **Medical History (Any pertinent test results or films you feel will help your therapist accurately diagnose and treat your condition)**
- ☐ **Loose fitting clothing**
- ☐ **Co-payment (If applicable, it is a payment due at the time services are rendered. It is in fulfillment of the contract you have with your insurance company. It can be satisfied with either cash, check, or major credit card)**
- ☐ **Insurance Card and Photo ID**
- ☐ **You have confirmed your appointment time and are prepared to arrive 10-15 minutes early to process the administrative aspect of your visit.**

Professional Plaza
3155 Route 10 East · Suite 112 · Denville, NJ · 07834
P: (973) 366 – 1600 · F: (973) 366 – 2400

PATIENT INTAKE FORM

PATIENT INFORMATION			
Patient Name:	E-Mail:		SS#: / /
Address:	City:	State:	Zip Code:
Telephone: H: C:	Date of Birth: / /	Sex: (circle one) M | F	Date of Injury: / /

How would you like to be reminded of your appointments (MUST CHOOSE ONE): ❑ E-Mail (provide email above) ❑ Phone Call: #_____ ❑ Text Message: #_____

Auto Related? ❑ Yes - State: _____ ❑ No	If Auto Accident: Date of Accident: / / Type of Accident (circle one): Driver | Passenger | Pedestrian
Work Related? ❑ Yes - State: _____ ❑ No	If Workers Comp, was accident with present employer? ❑ Yes ❑ No If No, who was employer: _____
Are you currently receiving Home Health Services? ❑ Yes ❑ No	If Yes, name of agency and what type of services? _____ If No, have you received services in the past 60 days? ❑Yes ❑No

Were you ever treated for outpatient physical therapy before? ❑ Yes ❑ No

PRIMARY INSURANCE INFORMATION		
Insurance Company:	Policy or Claim #:	Group #:
Policy Holder Name:	Date of Birth: (mm/dd/yy) / /	SS#: / /
Insurance Company Telephone:	Policy Holders Work Phone:	Holder: ❑ Self ❑ Spouse ❑ Dependant ❑ Other _____

SECONDARY INSURANCE INFORMATION ❑ Not Applicable (Backup if Auto, Workers Comp. or Litigation)		
Insurance Company:	Policy or Claim #:	Group #:
Policy Holder Name:	Date of Birth: (mm/dd/yy) / /	SS#: / /
Insurance Company Telephone:	Policy Holders Work Phone:	Holder: ❑ Self ❑ Spouse ❑ Dependant ❑ Other _____

EMPLOYER INFORMATION:		
Employer Name:	Employer Phone #:	Status: ❑ FT ❑ PT ❑ Retired ❑ Self ❑ Student ❑ Other _____
Address:	City / State:	Zip Code:

EMERGENCY CONTACT INFORMATION:		
Contact Name:	Phone:	Relationship: ❑ Parent ❑ Spouse ❑ Sibling ❑ Other: _____

PHYSICIAN INFORMATION:	
Name of referring Physician:	Phone:

I _____, authorize JointCare Physical Therapy to release 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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MEDICAL INTAKE QUESTIONAIRE

ALL SECTIONS MUST BE FILLED OUT IN ORDER TO ACCURATELY DOCUMENT AND BILL YOUR INSURANCE COMPANY ON YOUR BEHALF – THANK YOU!

Date of Surgery/Accident/Onset of Symptoms: _____

Medical History (check all that apply):

☐ Alzheimer's	☐ Dizziness	☐ Neurologic Disease
☐ Anxiety Disorders	☐ Fibromyalgia	☐ Osteoarthritis
☐ Autoimmune Disease	☐ Fracture/Suspected Fracture	☐ Osteoporosis/penia
☐ Cardiovascular Disease	☐ High Blood Pressure	☐ Pacemaker
☐ Cardiac Arrhythmia	☐ Hepatitis A/B/C	☐ Parkinson's
☐ Currently Pregnant	☐ History of Cancer	☐ Rheumatoid Arthritis
☐ Diabetes Mellitus Type 1/2	☐ HIV	☐ Stroke
☐ Depression	☐ Immunosuppression	☐ Traumatic Brain Injury

Other (Please Specify):_____

Are you currently ill? ❑ YES ❑ NO **Do you currently smoke? ❑ YES ❑ NO**

Current Occupation/Daily Activity:_____

Height/Weight (required to calculate Body Mass Index):_____

Current Medications (if you have a list, please provide to front desk): _____

_____

Circle a number you feel your pain is (or dizziness, if applicable):
(0 = no pain/dizziness and 10 = emergency room pain/extreme dizziness)

At Best:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
At Worst:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Have you fallen in the past year? ❑ YES ❑ NO

If YES: How many times? _____ Did you incur injury? ❑ YES ❑ NO

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CONSENT FOR CARE & TREATMENT

I, the undersigned, do hereby agree and give consent for Denville Physical Therapy, LLC (DBA, JointCare Physical Therapy) to furnish care and treatment to ***(patient)*** _____ that is considered necessary and proper in diagnosing or treating my/his/her condition.

Notice of Privacy Practices

As per HIPPA guidelines, I acknowledge that I have read and understand the notice of Privacy Practices for JointCare Physical Therapy, and may be furnished with a copy upon my request.

Benefit Assignment

I hereby assign medical benefits to which I am entitled, including Medicare, private insurance, and third party payors, to JointCare Physical Therapy. A photocopy of this assignment is to be considered as valid as the original.

Financial Policy Statement

If any payment is made directly to me for services billed by JointCare Physical Therapy, I recognize an obligation to promptly remit that amount along with any explanations of payment to JointCare Physical Therapy. I understand agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed including original charges, interest, collection agency fees, and attorney fees.

Billing and Benefits

It is the patient's responsibility to maintain all prescriptions, referrals, and authorizations as required by your insurance company. We will bill your insurance carrier as ***a courtesy to you*** in cooperation with ***Ford Practice Management Group***. We have called your insurance carrier for estimated insurance benefits, and they are reflected on the "Verification of Benefits" form.

Estimated coverage information is provided as a courtesy to our patients and is not intended to release them from total responsibility of treatment/payment. *Please be aware that this is not a guarantee of benefits.* Actual plan benefits can only be determined upon receipt and processing of your claims.
(Federal Regulation Code 29, Section 2560.503-1).

Worker's Compensation Clause

The above does not apply to those patients that are considered Worker's Compensation. However, be advised if you claim Worker's Compensation benefits and are subsequently denied, you will be held responsible for any remaining balance on your account. At that time, our Financial Policy will apply to you.

JointCare Physical Therapy sends a monthly newsletter filled with tips and information regarding your health. If at any time you wish to no longer receive this, please contact us. We respect your personal information and privacy.

I have read the above information and understand my responsibilities.

_____
Patient's Name **(PRINT)**

_____
Patient Signature Date

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24 HOUR CANCELLATION & 15 MINUTE LATE POLICY

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well being and gain of your physical abilities is something everyone in our office takes quite seriously.

Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore we have certain rules that need to be followed in order to ensure the most optimum results. As a courtesy, we will furnish you appointment lists specifying your appointment dates and times.

LATE: If you feel that you may be late for a scheduled appointment, please contact our Administrative Staff. Arriving 15 minutes after your scheduled appointment time may prevent us from providing you with a full treatment session. We will make every effort to care for you but rescheduling the appointment may be necessary.

CANCEL: With the exception of serious emergencies it is expected that you keep all your appointments. However, if you need to cancel an appointment we require 24 hours notice. In such a case, please call our Administrative Staff and arrange for a make-up appointment within the same week of the canceled appointment.

In an instance of a cancellation without 24 hours notice or no-show to a scheduled appointment, we reserve the right to charge you a $25.00 fee.

In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care. In those rare cases, we will inform your physician of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

We appreciate you choosing us as your healthcare provider and look forward to working with you to achieve your goals.

JointCare Physical Therapy

I have read and understand this policy:

Patient Signature: _____ Date: _____

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MEDICARE UPDATE

Attention Medicare Patients ONLY:

Effective October 1st, 2012, Medicare has placed a financial limit of $3700 per beneficiary on physical and speech therapy (combined) for services during the calendar year including inpatient, outpatient and home healthcare. Medicare, on an individual basis, may also request to review documentation supporting medical necessity to determine eligibility for continued treatment. After this cap is reached, patients may be responsible for the charges above the ***Government imposed limit***.

At JointCare Physical Therapy, we are here to help. Our office, along with our billing company, will assist you in coordinating your care within the cap limits.

You may receive information from Medicare in the coming months regarding changes in coverage. Further information regarding this policy is located in your beneficiary handbook. Additional information is available by calling (800) 633-4227 or visiting http://go.cms.gov/MedRev. If you have any further questions, please don't hesitate to ask.

Patient Signature:_____ Date:_____