Cross Keys PHYSICAL THERAPY

Account # ____________

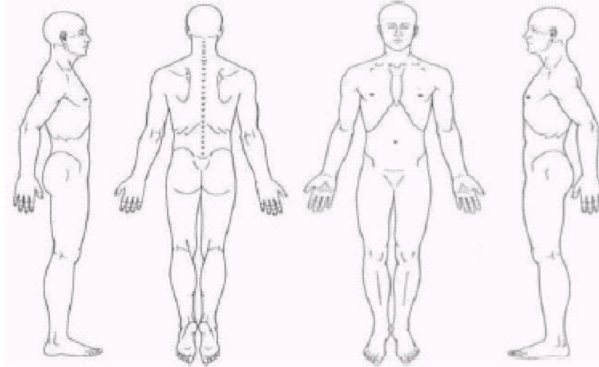
Patient Health Questionnaire

(MVA)

*Patient Name*____________________________________ *DOB*_______/_______/_______

1. ***Describe your symptoms/complaints or limitations:*** ____
   ____
   ____
2. ***Please describe how your problem began:*** ____
   ____
3. ***When did your symptoms begin/Specific date if possible:*** ____________________________________

   Did you have surgery? ☐ Yes ☐ No Date _______/_______/_______



(MARK ON PTICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS)

4. ***How often do you experience your symptoms?***
   - ☐ Constantly (76-100% of the day)
   - ☐ Frequently (51-75% of the day)
   - ☐ Occasionally (26-50% of the day)
   - ☐ Intermittently (0-25% of the day)
5. ***Please describe the nature of your symptoms?***
   - ☐ Sharp ☐ Dull (Pain) Ache
   - ☐ Numbness ☐ Shooting ☐ Throbbing
   - ☐ Burning ☐ Tingling ☐ Radiating
6. ***Since your symptoms began they have?***
   - ☐ Decreased
   - ☐ Not Changed
   - ☐ Increased
7. ***Indicate the intensity of your pain at rest:*** **(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)**
8. ***Indicate your pain with movement:*** **(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)**
9. ***Your symptoms are worse in:*** ☐ morning ☐ afternoon ☐ night ☐ increased during the day ☐ same all day
10. ***In the past*** have you been treated for the same problem? ☐ Yes ☐ No

    If yes, who did you see for this condition? ☐ MD ☐ Physical Therapist ☐ Chiropractor ☐ Other

    When and what treatment did you receive? ____
11. ***What is your occupation?*** ____

    Has your work status changed because of this condition? ☐ Yes ☐ No. If yes, how? _______________

    ____
12. ***Do you have high blood pressure?*** ☐ Yes ☐ No

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Patient Name____________________________________ ***DOB***_______/_______/_______

13. ***Do you have a heart condition or artery disease?*** ☐ Yes ☐ No

    If yes, please explain: ____

14. ***Do you have a pacemaker or defibrillator?*** ☐ Yes ☐ No
15. ***Are you pregnant?*** ☐ Yes ☐ No
16. ***Do you have diabetes?*** ☐ Yes ☐ No if yes, what type: _____________________________
17. ***Have you had any type of cancer?*** ☐ Yes ☐ No if yes, what type: ___________________________
18. ***Have you ever had a stroke?*** ☐ Yes ☐ No If yes, when: _________________________________
19. ***Do you ever have seizures?*** ☐ Yes ☐ No If yes, when was your last: _______________________
20. ***Do you have any type of metal implants?*** ☐ Yes ☐ No
    Including hip, knee or shoulder replacements: ____
21. ***Do you have osteoporosis?*** ☐ Yes ☐ No
22. ***Do you experience occasional dizziness?*** ☐ Yes ☐ No If yes, when: ________________________
23. ***Do you have a hiatal hernia?*** ☐ Yes ☐ No
24. ***Do you have any drug allergies?*** ☐ Yes ☐ No If yes, what: ______________________________
25. ***Please list all medications you are currently taking:*** _______________________________________

    ____

    ____

    ____

26. ***Please list any hospitalization/surgical procedures that have not been described elsewhere:***

    ____

    ____

    ____

Patient's Signature: ______________________________________ **Date:** ________________________

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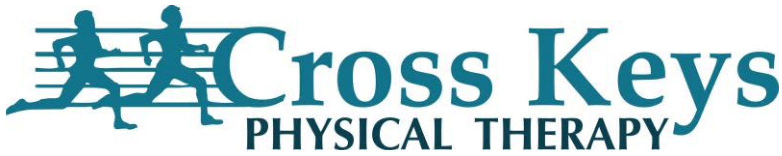

Account # ____________

PATIENT INFORMATION

PATIENT NAME: ____ DOB__________ □ M □ F

Emergency Contact Name: _______________________________________ **Phone No.:**__________________

PRIMARY INSURANCE: ____

Address: ____

ID/Claim #:____________________ Group #:________________ Copay $:________ Deductible $:_________

Phone No.:________________________________ Ext.:_______________ Fax No.:______________________

Policy Holder Name: _______________________________________ Relation: ____________________________

Policy Holder Date of Birth: _________________________________ SS#:________________________________

Date of Accident: ______________________________ Adjuster's Name: _______________________________

Have you been treated for this condition before? □Y □N if yes when: ___________________________

Was this treatment billed to your current insurance? □Y □N or was it due to □ MVA □ WC

*****If MVA, was PIP application Submitted to Insurance Care? □Y □N if no, you need to do this before insurance company will honor your claims.***

SECONDARY INSURANCE: ______________________________________ **Type:** □W/C □MVA □PERS.

Address: ____ Auth/Cert: □Y □N

ID/Claim #:____________________ Group #:________________ Copay $:________ Deductible $:_________

Phone No.:________________________________ Ext.:_______________ Fax No.:______________________

Policy Holder Name: _______________________________________ Relation: ____________________________

REFFERING DOCTOR: ___________________________________ Diagnosis: _________________________

Address: ____

Phone No.:_________________________ Fax No.:_________________________ UPIN No.:_______________

Did you have surgery? □Y □N If yes, give date: ___________________ Procedure: ______________________

NAME OF ATTORNEY (If applicable):____

Address: ____ Contact: __________________________

Phone No.:__________________________________ Fax No.:____

IS ALL OF THE ABOVE INFORMATION COMPLETE AND ACCURATE: □Y □N

SIGNATURE: ____ **DATE:** __________________________

Cross Keys PHYSICAL THERAPY

Account # ___________

Patient HIPPA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.
I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.
I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name: ___________________________________ Date: ______________________________

Signature: ____

- -

Disclosure of Insurance Information

New Jersey provides that patients disclose all insurance information to a Health Care Provider at their initial visit.

Cross Keys Physical Therapy will make a copy of the front and back of all your insurance card(s) – primary and secondary.

By signing this form, I am stating that all my insurance information has been given to *Cross Keys Physical Therapy,* and that I have no other insurance than those I have presented.

Print Patient Name: ___________________________________ Date: ______________________________

Signature: ____

Account # ___________

Appointment Policy

Our job is to help you reach your goals and achieve your maximum potential in physical therapy. At Cross Keys Physical Therapy we are very proud of our success rate. In order for us to help you reach your goals, it is important for you to keep all of your scheduled appointments. We cannot help you if you are not here. Keeping your appointments will help you meet all of your goals and prepare you for discharge.

To do this best, we reserve an appointment for each of our patients. Since we strive to meet all patient appointments requests, we ask that you keep you scheduled appointment time. However, if you cannot, we will be glad to cancel and reschedule a makeup appointment for you. This will allow us to release your reserved appointment time to another patient.

Please call the location your appointment is scheduled at. (See below for telephone number) **Must call at least 24 hours in advance**, For **Monday** appointment, patient must notify us before 3:00 pm on Friday. ***Any appointment cancelled after 24 hours will be charged a $25.^{00} cancellation fee. This fee will have to be paid before next appointment.***

The insurance companies view patients with missed appointments as "Non-Compliant". Patient cancellations and "no shows" will negatively affect insurance certifications for future visits. (If your prescription is for 3 times per week and you miss an appointment, you may reschedule it for later that week, or make it up the following week by coming in 4 times.)

If you are a Workers Compensation Patient you must be aware that your Employer and the Workers Comp Insurance Carrier will be notified of all missed appointments.

Early discharge or dismissal from your physical therapy program may occur for the following reasons:

1. Any patient who cancels 2 appointments without making them up.
2. Any patient who "No Shows" for appointments and does not reschedule, and/or return our call to reschedule.

At the completion of you therapy a Discharge Letter and Re-evaluation will be sent to your doctor.

SIGNATURE: ____________________________________ **DATE:** ______________________

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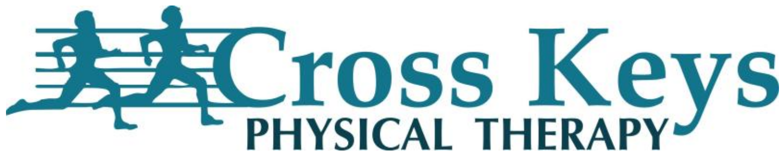


Account # ____________

MVA Questionnaire

Dear Patient,

At *Cross Keys Physical Therapy*, we know being involved in an automobile accident can be a traumatic and unpleasant experience. To provide you with the best health care, it is important we are aware of certain details relating to this accident so we understand your condition and expedite the billing process. Please take a few minutes to answer the following questions.

Name: ______________________________ Date: ______________________

Date of accident: ______________________________ Date accident reported: ____________

Brief description of accident: ____

____

____

In your estimation is there any reason that you feel you were at fault for this accident? ☐YES ☐NO

Were you hospitalized for this accident? ☐YES ☐NO If yes, for how long___________ If no, did you seek medical attention following accident? ☐YES ☐NO If yes, when______________________

Doctor's name that rendered service ____

Have you ever been treated for similar injuries in the past? ☐YES ☐NO Date: __________________

Relating to injuries with this accident have you received?

Physical therapy? ☐YES ☐NO if yes, when___________ Are you treating now ☐YES ☐NO

Chiropractic service? ☐YES ☐NO if yes, when___________ Are you treating now ☐YES ☐NO

X-ray or MRI's? ☐YES ☐NO If yes, when___________ Radiology facility________________________

Have you received surgery for injuries relating to this accident? ☐YES ☐NO If yes, when___________________

Doctor who performed surgery___________________________ procedure _________________________________

INSURANCE

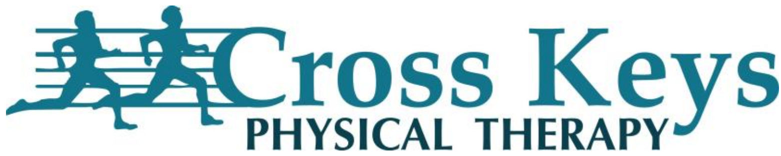
Have you notified your automobile insurance of this accident? ☐YES ☐NO If yes, when Date: ________________

Have you notified your automobile insurance that you are treating for medical condition relating to this accident?
☐YES ☐NO

Have you filled out and returned a **Personal Injury Protection Form** (PIP)? ☐YES ☐NO
If yes, when Date: _______________

Have you been scheduled for an **Independent Medical Exam** (IME)? ☐YES ☐NO
If yes, when Date: _______________

***Please notify us of any personal insurance you have to allow us to bill them as a secondary to cover any balance which may remain after your auto insurance has paid.**



Account # ________________

MVA INSURANCE PAYMENT AGREEMENT & GUIDELINES

For and in consideration for services rendered I do hereby agree to pay Cross Keys Physical Therapy the full and entire amount not covered by my insurance.

I am aware that my DEDUCTIBLE amount is $______________and my COINSURANCE IS 20%.

I understand that under New Jersey Law I am responsible for the DEDUCTIBLE & COINSURANCE BALANCES. If these balances apply to services rendered by *Cross Keys Physical Therapy*, I want them sent to:

My MEDICAL INSURANCE CARRIER ____
Patient Signature

*******I understand that my Medical Insurance carrier may apply the Deductible / Coinsurance / Co-payment required under my policy. I understand that I may be billed for this balance. *******

I understand if I have no MEDICAL INSURANCE I will be responsible for the 20% COINSURANCE.

I agree to make payments in good faith towards the balance due while waiting on settlement from PIP claim I have filed with my attorney's office. Please make payment arrangements with billing office.
Billing office phone number is (856) 374-3707 ext. 17 or 18

____
Patient Signature

I understand MVA INSURANCE requires Precertification.

I agree to notify Cross Keys Physical Therapy of any and all insurance changes relating to my care. This includes eligibility status regardless of legal representation. I accept the responsibility of contacting my insurance upon request of the Billing Office Staff if there are any problems with my insurance. Failure to comply with the requests of Cross Keys Physical Therapy Staff in regards to my insurance will hold me responsible for any unpaid balances.

I authorize payment for services rendered by *Cross Keys Physical Therapy* to be directly paid to *Cross Keys Physical Therapy* 151 Fries Mill Road Building 600 Suite 1 Turnersville, NJ 08012.
I agree to forward to Cross Keys Physical Therapy any payments issued to me.

I understand that if my account if placed in Collections the balance due will include and "Costs for Collection" incurred by Cross Keys Physical Therapy.

I understand a $30 fee will be charged for returned checks.

Print Name: ________________________________ Date: ______________________

Signature: ________________________________ Witness: ______________________

Account # _______________

ASSIGNMENT OF RIGHT OF ACTION

I, ____do hereby assign any right of action that I may have against ____my PIP Insurance Company to Cross Keys Physical Therapy for non-payment of my medical bills arising from, the injuries that occurred on ________________________________.

I further authorize Cross Keys Physical Therapy to institute a lawsuit for arbitration and or Superior Court against my insurance company in my name, using an attorney of their choice to recover fees owed to Cross Keys Physical Therapy related to medical treatment provided to me.

I acknowledge that I will cooperate with all efforts by Cross Keys Physical Therapy and their attorneys to recover any outstanding medical bill for treatment rendered to me related to the above reference accident. This may include authorizing the release of my medical records and appearing in court or at an arbitration proceeding as directed by Cross Keys Physical Therapy's attorneys.

I further acknowledge that while Cross Keys Physical Therapy will be pursing claims on my behalf against my insurance carrier for bills not paid, I am aware that I am responsible for any co-payments, deductibles, and co-insurance not covered by my insurance carrier.

Patient Signature:____

Date:_______________________________