CARROLL
PHYSICAL THERAPY

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

Phone: (973) 366-1600
Fax: (973) 366-2400

CARROLL
PHYSICAL THERAPY

PATIENT INTAKE FORM

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Email: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (H): _____ (C): _____

How would you like to be reminded of your appointments? *(MUST CHOOSE ONE)*

☐ E-Mail *(provided email above)* ☐ Phone Call (#: _____) ☐ Text Message (#: _____)

Are you currently receiving Home Health Services? ☐ Yes ☐ No

If YES, name of agency and 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

Has a doctor prescribed physical therapy? ☐ Yes ☐ No

If YES, Doctor's Name: _____ Phone: _____

If NO, Primary Care Physician's Name: _____ Phone: _____

SOCIAL HISTORY

Occupation: _____

Work Status: ☐ FT ☐ PT ☐ Retired ☐ Self ☐ Student ☐ Not Employed ☐ Other: _____

Hobbies/Activities: _____

Living Status: ☐ Alone ☐ With Family ☐ With Spouse ☐ Other: _____

Home Layout: ☐ 1-Story ☐ 2-Story Do you smoke? ☐ Yes ☐ No

Number of steps to enter house: _____ Number of steps in house: _____

Have you fallen in the past year? ☐ Yes ☐ No

If YES, how many times? _____ Did you incur any injuries? _____

If YES, please describe the context of the fall (slipped on ice, fell on curb, etc.):

_____

_____

Professional Plaza
3155 Route 10 East, Suite 112
Denville, NJ 07834

Phone: (973) 366-1600
Fax: (973) 366-2400

Patient Name: _____

EMERGENCY CONTACT INFORMATION

Contact Name: _____ Phone: _____

Relationship: ☐ Parent ☐ Spouse ☐ Sibling ☐ Other: _____

I give Carroll Physical Therapy permission to send automated appointment reminders by the above checked methods. I give consent to receive calls/voicemails to the primary number on file in regards to my appointments. Carroll Physical Therapy will only review personal/medical information directly to you unless otherwise requested above.

_____ _____

Patient/Guardian Signature Date

Professional Plaza
3155 Route 10 East, Suite 112
Denville, NJ 07834

Phone: (973) 366-1600
Fax: (973) 366-2400

CARROLL
PHYSICAL THERAPY

MEDICAL INTAKE QUESTIONNAIRE

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

Patient Name: _____

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 If YES, please describe: _____

Current Occupation/Daily Activity: _____

Height (required to calculate BMI): _____ Weight (required to calculate BMI): _____

CURRENT MEDICATIONS
(please attach a supplemental list, if necessary)

Medication Name	Dosage	Frequency	Route of Administration

Professional Plaza
3155 Route 10 East, Suite 112
Denville, NJ 07834

Phone: (973) 366-1600
Fax: (973) 366-2400

Patient Name: _____

HISTORY OF CURRENT CONDITION

Describe your symptoms: _____

_____

When did symptoms begin? _____

Diagnostic Tests:

☐ X-rays ☐ CT-scan ☐ MRI ☐ EMG ☐ Doppler ☐ Other: _____

Functional limitations:

☐ Self-care (dressing, sleeping, etc.)

☐ Walking and moving around (walking, stairs, etc.)

☐ Changing and maintaining body positions (prolonged sitting/standing, getting out of chair, etc.)

☐ Carrying, moving and handling objects

What makes your symptoms worse? _____

_____

What makes your symptoms better? _____

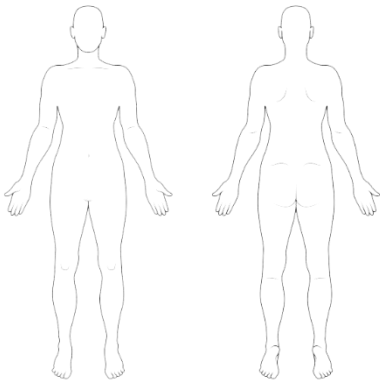
_____

Have you had other treatments? If so, describe: _____

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

Circle on the diagrams below where you feel pain:



What are your goals for physical therapy?

_____

_____

Professional Plaza
3155 Route 10 East, Suite 112
Denville, NJ 07834

Phone: (973) 366-1600
Fax: (973) 366-2400

CARROLL
PHYSICAL THERAPY

CONSENT FOR CARE & TREATMENT

I, the undersigned, do hereby agree and give consent for Denville Physical Therapy, LLC (DBA, Carroll 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 Carroll 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 Carroll 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 Carroll Physical Therapy, I recognize an obligation to promptly remit that amount along with any explanations of payment to Carroll 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.

Carroll 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 Name **(PRINT)**: _____

_____ _____
Patient Signature Date

CARROLL
PHYSICAL THERAPY

ACCOUNTABILITY AGREEMENT

Our mission at Carroll Physical Therapy is simple - to commit to providing physical therapy the way it was intended to be.

Our commitment to you is this:

- To listen to and address your needs in order to help you achieve your goals.
- To provide you with personalized, evidence-based, and effective care.
- To communicate with your doctor and healthcare professionals about your progress.
- To remain accessible and available to help you during and after your time at Carroll PT.
- To remain affordable by maintaining independent, in-network status with your insurance (unless otherwise stated on your insurance verification).
- To understand that things come up, and not charge you for cancellations/unattended appointments.

We ask that you reciprocate a similar commitment in agreeing and acknowledging this:

- To communicate my needs, expectations, and concerns to my therapist.
- To comply with my home exercise program and recommendations, as it is for my benefit.
- To make every effort to follow my doctor's and therapist's prescribed plan of care.
- To attend physical therapy as recommended in the plan of care set by my doctor and physical therapist. *Research supports that attending physical therapy no less than 2-3 per week ensures a greater likelihood of a successful outcome (see article citation below).*
- To schedule my appointments in advance to ensure I get the appointment times that are best for me.
- To make every effort to cancel appointments with at least 24 hours notice, so that someone else may benefit from the available appointment.

Both, myself and Carroll Physical Therapy, reserve the right to communicate concerns and possibly discontinue care, if either party are not meeting the above standards of care.

I fully understand and acknowledge the above.

Patient Name **(PRINT)**: _____

_____ _____

Patient Signature Date

Bastan M, Toher R, Nula M, Harvey J. Association among select clinical data and successful completion of a treatment plan in an outpatient orthopedic physical therapy setting. *Orthopaedic Practice*. 2017; 29(4): 200-02.

CARROLL
PHYSICAL THERAPY

NOTICE OF PRIVACY PRACTICES / INFORMATION POLICIES

This notice describes how your health information may be used and disclosed and how you can access this information. Carroll Physical Therapy will always keep your health information secure and private.

Ways in which your confidential information may be used or disclosed without your authorization:

- The law permits us to disclose information to those involved in your treatment.
- We may disclose your information for billing purposes, gaining insurance or benefits information, insurance authorization and payment for services.
- Your healthcare information may be used during normal healthcare operations.
- We may use your information to contact you, to call to remind you of your appointments, for scheduling purposes or to inform you of insurance benefits. This may involve leaving messages on an answering machine or with the person who answers the phone.
- We may release some or all of your information when required by law.
- Your authorization is required to disclose your health information to other healthcare providers, individuals or third parties requesting information about you.

You have the right to:

- Know of any uses or disclosures we make with your health information beyond the above normal uses.
- Transfer copies of your information to another practice.
- See and receive a copy of your health information, with a few exceptions. Request must be in writing. (We may charge a reasonable copy fee.)
- Request that we amend your confidential information. Request must be in writing. (If we agree with the request, we will not alter the earlier document, but will add an addendum.)

Carroll Physical Therapy will maintain the privacy of your confidential information as required by law and by the notice currently in effect.

If you feel that your rights have been violated, you may contact:

Department of Health and Human Services
200 Independence Avenue SW, Room 509F
Washington, DC 20201

You will not be penalized for filing a complaint. However, before filing a complaint or for assistance regarding the privacy of your health information, please contact Daniel Carroll with Carroll Physical Therapy at 973-366-1600.

Patient Name **(PRINT)**: _____

_____ _____

Patient Signature Date

We may leave a message on your answering machine or with any individual that may answer your telephone: ☐ Yes ☐ No

DISCLOSURE OF HEALTH INFORMATION

If you choose to allow us to disclose your personal health information to someone other than yourself please list them below.

I allow Carroll Physical Therapy to disclose my personal health information to the person(s) named below:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____