LightPort
Physical Therapy & Spa

Patient Summary

Date_____

Personal Information

Name_____ Date of Birth_____

Street Address_____ Age____ Gender: M__ F __

City_____ State_____ Zip_____

Contact Information

CellPhone_____ HomePhone _____
(Parent/Guardian's # if patient under 18 years old)

Email_____ WorkPhone _____
(automatic 24hr advance appointment reminders)

Parent/Guardian Name_____ Phone _____
(if patient under 18 years old)

Emergency Contact_____ Phone_____

Contact Relationship: **__Spouse __Mother __Father __Sibling __Child __Guardian __Other**

Medical History

Referring Physician _____ Location_____
Primary Care Physician _____ Location_____
Date of next Physician visit _____

Please check the appropriate response:

- Is your current condition auto accident related? _____YES _____NO
- Is your current condition work related? _____YES _____NO
- Have you received or are you receiving physical, occupational, massage, chiropractic or pain management from any other facility or provider at this time? _____**YES** _____**NO**
- If yes, please explain _____

Whom may we thank specifically for this referral_____

LightPort
Physical Therapy & Spa

Health Questionnaire

Patient Name _____ **Date** _____

1) Date of Injury _____Date of Surgery (if applicable) _____

2) Please describe your symptoms (including how & when they started, aggravating & relieving factors, etc.)

_____

_____

_____

3) How often do you experience your symptoms?
____**Constantly** (100% of the day) ____**Frequently** (25-75% of the day) ____**Intermittently** (0-25% of the day)

4) What describes the nature of your symptoms?
____**Sharp** ____**Dull Ache** ____**Numb** ____**Burning** ____**Shooting** ____**Tingling**

5) How are your symptoms changing?____**Getting Better** ____**Not Changing** ____**Getting Worse**

6) During the past 4 weeks:

Indicate the average intensity of your symptoms: 0 1 2 3 4 5 6 7 8 9 10
None **Worse Imaginable**

7) Who have you seen for your symptoms? ____**Medical Doctor** ____**Chiropractor** ____**No One**
What treatment did you receive?_____ When?_____

What tests have you had? X-Rays _____ MRI_____ Other_____
(date) (date) (date)

8) Have you had similar symptoms in the past? _____Yes _____No
If yes, please explain_____

9) In general, your overall health right now is?
_____**Excellent** _____**Very Good** _____**Good** _____**Fair** _____**Poor**

10) Do you exercise regularly? _____**YES** _____**NO**

11) How would you consider your occupation? ____**active** ____**sedentary**

12) How would you describe your dietary habits?
____**Excellent** ____**Very Good** ____**Good** ____**Fair** ____**Poor**

13) Do you smoke? _____**YES** _____**NO**
If yes, how many packs a day?_____ **For how many years?**_____

14) How much sleep do you get per night? _____

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Physical Therapy & Spa

Health Questionnaire continued..

Please check/circle if you have ever (in your life) had, or do you presently have any of the following:

___Osteoporosis ___Bone Joint Problem ___Arthritis/Rheumatism
___Allergies ___Back Trouble ___Breathing Problems (any kind)
___Broken Bones/Dislocation/Sprains ___Cancer or Tumor
___Skin Disease or Sores that won't heal

___Dizziness/Fainting ___Epilepsy/Seizure Disorder ___Fibromyalgia Syndrome
___Headaches/Migraines ___Head/Spinal Injury ___Heart Disease/Chest Pain
___High Blood Pressure ___High Cholesterol ____Pacemaker/Defibrillator
___Pregnancy (current) ___Hernia/Rupture ___Diabetes - Type I / Type II
___Stroke/Neurological history ___Swelling of Feet or Joints
___Urinary Incontinence ___Surgeries (list below)
___Other (explain) _____

_____

_____

Surgery/Procedure_____ Date_____

Surgery/Procedure_____ Date_____

Surgery/Procedure_____ Date_____

Medications

Are you allergic to any medications? _____**YES** _____**NO**

If YES, what?_____

If you are currently taking any medications please list below:

1._____ 4._____

2._____ 5._____

3._____ 6._____

I certify that I have reviewed and understand the above information supplied by me, and that it is true and correct to the best of my knowledge. I hereby consent to such treatment, procedures and patient care which, in the judgment of my physical therapist and/or physician, may be considered necessary or advisable while a patient at LightPort Physical Therapy.

Patient Signature/Guardian Signature_____ Date_____

LightPort
Physical Therapy & Spa

LightPort Physical Therapy

Assignment of Benefits Financial Policies

Thank you for choosing **LightPort Physical Therapy** for your rehabilitation needs. We appreciate that you have entrusted us with your health care and are committed to providing you with the best patient care possible. Please carefully read through the following financial information.

Because healthcare benefits and coverage options have become increasingly complex, we have developed these policies to help you better understand your responsibilities as a patient and eliminate any unnecessary confusion. We will do our best to assist you with understanding your proposed treatment and in answering questions related to submitting your insurance claim for reimbursement. Adhering to these policies will enable us to focus increased attention on providing quality rehabilitative services to our patients and run our clinic more efficiently. If you have any questions in regard to the following information please do not hesitate to ask any of our staff members.

Authorization to Release Information

I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated. I hereby authorize Provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to the Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to the Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Financial Responsibility

I have requested professional services from **LightPort Physical Therapy** ("Provider") on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advanced.

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to: **LightPort Physical Therapy** - 355 Bloomfield Ave. Caldwell, NJ 07006 or If my current policy prohibits direct payment to **LightPort Physical Therapy**, I hereby also instruct and direct you to make out the check to me and mail it as follows: **LightPort Physical Therapy** - 355 Bloomfield Ave. Caldwell, NJ 07006 for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. If payment is mailed directly to me I will bring in the check and explanation of benefits within 48 hours of receipt. I also understand that should my insurance company send payment to me, I will forward the payment to **LightPort Physical Therapy** within 48 hours. I agree that if I fail to send the payment to **LightPort Physical Therapy** and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies.

Patient Signature/Guardian Signature_____ **Date**_____

Insurance Coverage:

As a service to our patients, **LightPort Physical Therapy** is more than happy to directly bill your insurance for services rendered, but it is our policy that the patient is ultimately responsible for payment of the services received from **LightPort Physical Therapy**. Furthermore, the patient is responsible for understanding their insurance coverage in relation to covered services and is responsible for providing **LightPort Physical Therapy** with the most current insurance information.

In Network: Our clinic and therapists participate in the majority of regional health plan networks allowing you the benefit of "in-network" coverage. We make every attempt to verify your current insurance coverage. Verification of benefits is NOT a guarantee of payment. Information we collect includes: effective dates, deductibles, co-payments and co-insurance amounts. We will try and review this information with you at your next visit. If you are unfamiliar with any of the terms used to explain your insurance benefits, please don't hesitate to ask one of our staff members. Please remember that any changes made to your insurance policy, and the time of year billing is submitted may affect coverage and reimbursement rates. We do not routinely research why an insurance carrier has not paid or why it paid less than anticipated.

Out of Network: You are responsible for meeting the out of network deductible before your insurance will begin to reimburse for the services rendered. You are responsible for any co-payments and/or coinsurances. As a courtesy, we will submit claims for payment to your insurance company. Your "out-of-network" benefits for outpatient physical therapy will be clearly explained in your insurance policies' schedule of benefits. It is your responsibility to obtain that information. Deductible and Co-payments are part of you contractual agreement with your insurance company and it is our responsibility as participating providers to collect those fees. **Co-payments are due at each visit.** If your insurance company reimburses more than the billed amounts we will reimburse you immediately upon overpayment.

Medicare: Our therapists are participating providers with Medicare, and we will attempt to bill Medicare as well as any supplemental insurance company provided. Physical therapy may have a covered service up to $1860 per year, and you are financially responsible for any co-insurance or annual deductible as applicable.

Worker's Compensation and Motor Vehicle Accident: It is your responsibility to provide us with the name and address of the insurance carrier along with your claim number. If we do not have verifiable billing information before your second appointment, your therapy will continue either on a cash basis until we receive the necessary billing information pertaining to your injury, or we obtain private insurance information. If, for any reason, your claim is denied, we will attempt to bill your private health care insurance, but please understand that ultimately you are responsible for full payment. Any attorney "letter of protection" for claims being disputed or in litigation will be discussed on a patient -by- patient basis and will not always be an acceptable form of payment guarantee. If that is the case we will need alternate insurance information or transfer your account to a cash pay basis. If your claim is in a "deferred" status we will need to have private insurance information on file in the event your claim is denied or pending litigation.

No Insurance / Cash Rate: We believe that no one should be denied physical therapy services secondary to lack of insurance coverage. Our clinic offers a discounted cash rate to those who do not have appropriate insurance coverage. Payment will be required at the time of service unless arrangements are made in advance. Please inquire about our current cash pay rate if it is applicable to your situation.

Patient Signature/Guardian Signature_____ **Date**_____

LightPort
Physical Therapy & Spa

Financial Policies continued..

Returned Checks: A $13 NSF (non-sufficient funds) fee will be charged for any checks returned to our office because of insufficient funds. If we receive a returned check, we will notify the patient or responsible party immediately and request that a cash payment be brought to one of our location within 24 hours to replace the amount of the full amount of the check.

Financial Assistance Program: We have a payment assistance program for qualifying families with limited incomes and/or extenuating circumstances. To determine whether your family qualifies for this program please do not hesitate to ask any of our staff members.

COLLECTIONS: If your account is more than 90 days past due, without an established payment plan on file. If you do not pay your bill following our internal collection efforts, your account will be sent to an outside collection agency. If your account is sent to a collection agency, you will need to contact them directly to settle your balances.

REFUNDS: A refund is issued when an overpayment have been identified. If you feel a refund is due, please contact our billing office at 201-253-5379.

Attendance Policy

At **LightPort Physical Therapy** we strive to give all patients the personal attention they deserve. The following guidelines have been established in order to achieve this goal. Please sign your agreement to our attendance policy below.

1) I acknowledge that any missed appointments interrupt the continuity of my care and may lead to slower recovery.

2) I understand that if I am late for a scheduled appointment, I may not be able to be seen that day.

3) If I need to cancel an appointment, I will give 24 hours in advance to notify the office. I will leave a voicemail if my call is not during normal business hours. I understand there is a $42.00 fee for a cancellation without proper notice. I understand that this will be billed to me and is not covered by insurance (last minute emergencies are excused of course).

4) I understand there is a $42.00 fee for missing a scheduled appointment without any notification. I understand that this will be billed to me and is not covered by insurance (last minute emergencies are excused of course).

5) I understand that if I miss 2 or more consecutive appointments without notice, I may be discharged from physical therapy and I will need a new referral from my physician to restart physical therapy

I, _____ have read the above stated policy and agree to be responsible for my health and for any fees associated with my inability to adhere to this policy.

Patient Signature/Guardian Signature_____ Date_____

LightPort
Physical Therapy & Spa

Authorization to Release Information

Release of Information:

I, the below named patient, hereby authorize **LightPort Physical Therapy** to release to any third party (such as an insurance company or governmental agency, example: Anthem BC/BS, UHC, or Medicare) any medical condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

Privacy Practices:

I, the below named patient, understand that I am entitled to certain privacy rights regarding protected health information according to the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I also understand and have been given the opportunity to receive a copy of the entire Notice of Privacy Practices prior to signing this consent and understand that I may revoke this authorization in writing, except to the extent that action has already been taken.

Content to Disclose Patient Information / HIPPA:

I, the below named patient, parent or guardian understand this center's Notice of Privacy Practices and give permission for my (my child's, child under my guardianship) protected health information to be disclosed for the purposes of communicating results, findings, care decisions, legal matters and appointments/scheduling to my doctors involved in my care as well as my lawyer representing me, as well as the family members listed below.

Consent to Leave Messages on Your Answering Machine:
(please initial one answer below)

YES Please leave me messages_____ **NO** Please do not leave me messages_____

Family Members and/or Legal Guardian (Please list family members and legal guardians below that may have access to information about you or your child from **LightPort Physical Therapy**).

1._____

2._____

3._____

Patient Signature/Guardian Signature_____ Date_____