COMPASSIONFIRST REHAB

IMPROVING LIVES THROUGH EXCELLENT SERVICE

WELCOME

Welcome to CompassionFirst Rehab Services LLC. It is a privilege that you have chosen us to guide you through your rehabilitation process. We understand filling out any paperwork can be arduous so we did our best to simplify the process, put only the important information and strictly comply with HIPAA regulations. Kindly bear with us as we try to obtain all the essential details to enable us to start the best quality of therapy care foryou!

PATIENT INFORMATION

Patient Name: _____ Sex: _____

Address: _____ Status: _____

Social Security #: _____ Home #: _____

Date of Birth: _____ Cell #: _____

Age: _____ Work #: _____

Do we have permission to leave a detailed message on your answering machine if we are unable to reach you in person? ☐ Yes ☐ No

If yes, which number you prefer to leave a message? _____

Email Address: *(CompassionFirst Rehab will not share, sell or trade your information)* _____

Automated Appointment Reminder preference: ____Phone Call___Text____Email

Referring Doctor: _____ Clinic/Hospital: _____

Patient's Employer: _____ Patient's Spouse or Parent: _____

How did you hear about us? _____

In case of emergency, please contact: (List a friend or relative that can be reached during office hours)

Name: _____ Phone #: _____ Relationship: _

If patient is under the age of 18, name of parent/guardian completing and signing documentation:

Name: _____ Phone #: _____ Relationship: _

CONSENT TO RECEIVE TREATMENT

By signing below, I agree to the following:

- I voluntarily give CompassionFirst Rehab Services LLC my consent to receive services which may include diagnostic procedures, examinations, and treatment according to the recommended plan of treatment as discussed with my therapist. I understand that physical therapy involves manual techniques that require appropriate physical contact by the health care provider and staff. I agree to work with CompassionFirst Rehab to maximize my progress towards mutually-planned treatment goals which have been authorized by my physician.

Signed: _____ **Date:** _____

(Parent/Guardian's signature if child is under 18 years old)

Date of Initial Evaluation (To be filled in by Therapist):

PT _____ **OT** _____ **ST**_____

AUTHORIZATION TO RELEASE INFORMATION/HIPAA

Authorization to Release Information
I, the below named patient, hereby authorize CompassionFirst Rehab Services LLC 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 (HIPAA). 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.

CONSENT TO DISCLOSE PATIENT INFORMATION / HIPAA 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 Who may have access to information about you or your child from CompassionFirst Rehab Services LLC.)

Name:_____ Relationship: _____

Name:_____ Relationship: _____

Name:_____ Relationship: _____

I authorize CompassionFirst Rehab Services to discuss my medical and/or billing information with the above-named person(s).

_____
Printed name, Signature and Date

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY/ERISA-AUTHORIZED REPRESENTATIVE FORM

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 write check to me and mail it directly to Provider.

Financial Responsibility

I have requested professional services from 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 such services. I understand that all fees for said services are due and payable on the date services are rendered. 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 as well as any denied services.

If your insurance company requires scripts, doctor's notes or referrals, it is your responsibility to bring them to your appointment. Failure to do so may result in either rescheduling your appointment or you being responsible for payment at the time of service.

I hereby instruct and direct_____Insurance Company to pay by check made out and mailed to: **COMPASSIONFIRST REHAB SERVICES LLC, 46 NEWELL DR., BASKING RIDGE NJ 07920,** or If my current policy prohibits direct payment to CompassionFirst Rehab Services LLC, I hereby also instruct and direct you to make out the check to me and mail it as follows: **COMPASSIONFIRST REHAB SERVICES LLC, 46 NEWELL DR., BASKING RIDGE NJ 07920** 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 ONE (1) week of receipt.

ERISA Authorization

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits; claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

Patient or Parent/Guardian Signature_____Date_____

ACKNOWLEDGMENT OF RESPONSIBILITY

To our patients:

As their policy, a few insurance companies direct providers to request their patients to pay the bill in full when services are rendered. However, we do not want to put you in a financial bind so to enable us to extend some courtesy, we will submit your claims to your insurance company in your behalf and when you receive their correspondence and/or payment, we would greatly appreciate if you can endorse such payment to our office the soonest.

Please note that we provide these services to our patients provided that the following are agreed upon as indicated by your initials below:

- **To Blue Cross/Blue Shield patients only** -- Some plans will send checks directly to the patient in his/her name instead of sending them directly to our facility in our name. Kindly bring the check/s, usually attached to an Explanation of Benefit(s), to our office. The co-insurance that you pay, along with the checks you will receive from your insurance company, are considered payment in full.

  I agree to give the payment AND copies of all correspondence to the office within 14 days of receiving the information myself. Checks not received by CompassionFirst Rehab Services will be given 60-days of grace period. Following the 60-day period, interest will accrue at 1.5% per month for those checks not delivered to COMPASSIONFIRST REHAB SERVICES LLC.

  _____(initial please)

- I understand that if there is a claim that my insurance company says that it was processed and subsequently a check was sent to me but which I dispute or claim that I did not receive, I understand that a conference call will be arranged with my carrier, the billing office and myself.

  _____(initial please)

- I understand that if I deposit an insurance check and pay the amount issued via credit card, I will be responsible for a 3% surcharge in addition to the monies owed. Monies paid by providing a personal check/bank check/postal money order/cash will not incur any additional fee or surcharge

  _____(initial please)

The process involving claims processing may be tedious and laborious so we ask for your patience and understanding on the matter. Thank you very much!

I agree with the policy as stated above and was given a copy for my records:

Patient or Parent/Guardian Signature_____ Date_____

Signed copy: Front Desk Initials _____

CANCELLATION AND BROKEN APPOINTMENT POLICY

We would like you to be aware of our cancellation and broken appointment policy. **Any appointments cancelled or broken within 24 hours of their scheduled time will be assessed a fifty dollars ($50) fee which will be directly billed to you as an out-of-pocket expense.**

If a cancellation is inevitable, we request that you notify us the soonest by phone 908-499-0208 to enable us to accommodate another patient who may want to take the slot.

We strive our very best to establish a mutually-beneficial working relationship between the patient and the physical therapist. Success will depend on the willingness and dedication of the patient to adhere to their home exercise program and if he/she attends all appointments as scheduled by the therapist. **It is of utmost importance that each patient adhere to every scheduled appointment.**

By signing below, you acknowledge that you have read our policy and commit yourself to a successful physical therapy program.

Signed: _____ **Date:**_____

(Parent/Guardian's signature if child is under 18 years old)

As a courtesy to our patients, we offer the option of paying on a weekly basis. If you prefer to make payments this way, instead of paying your cost at each visit, we require your credit card authorization on file.

Please provide your credit card information below:

Name on Card _____

Account Number _____

Expiration Date _____

3 or 4 digit security code (see back of card)_____

Signature_____

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HEALTH QUESTIONNAIRE

Patient's Name:_____Date: _____
Height:_____Weight: _____

Please write the appropriate response on the following (YES or NO)

Is your current condition auto accident related? _____

Is your current condition work related? _____

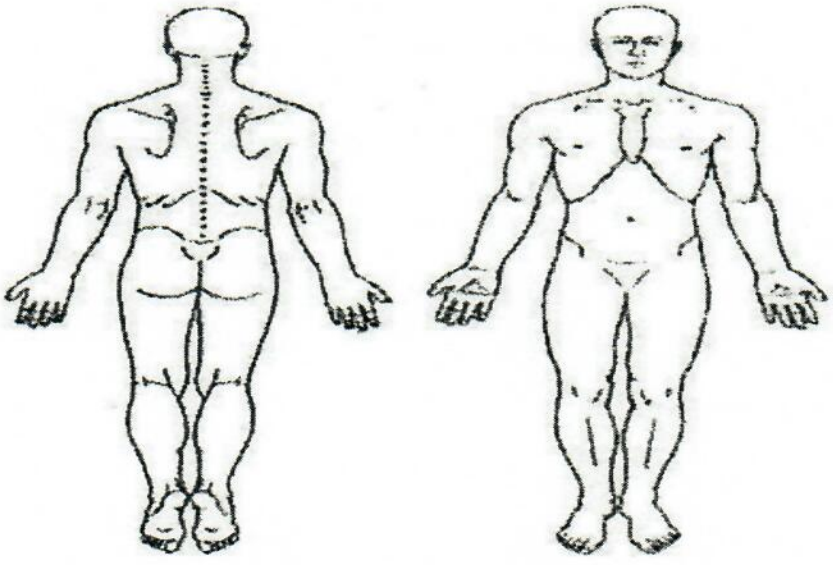
Have you received or are you receiving physical, occupational, massage, chiropractic or pain management from any other facility or provider at this time? If yes, please explain.

_____
_____
_____

HISTORY OF PRESENT CONDITION

What are you seeing us for? _____
_____
_____
_____

Please indicate where you have pain/symptoms:



When did this issue begin?_____

Describe the history of this problem (i.e. how it started?)_____

Was the onset of your symptoms gradual or sudden?

Have you had similar symptoms in the past? (Yes or No)

How often do you experience your symptoms?

- ☐ Constant (100% of the day)
- ☐ Frequent (25%-75% of the day)
- ☐ Intermittent (0-25% of the day)

Have you consulted any of the following for your symptoms?

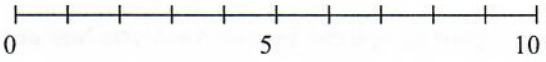
- ☐ Medical Doctor
- ☐ Other _____
- ☐ No one

Please list any current medications, including over the counter and supplements:

How would you describe your symptoms? (select all that apply)

- ☐ sharp
- ☐ dull
- ☐ numbness
- ☐ tingling
- ☐ other _____
- ☐ throbbing
- ☐ shooting
- ☐ aching
- ☐ burning

Please indicate the average intensity of your symptoms (0-lowest, 10-highest):



As you go through your day, do your symptoms get worse or better?:

Does pain ever wake you up at night? _____

What aggravates your symptoms?

- ☐ sitting
- ☐ lying down
- ☐ walking/running
- ☐ up/downstairs
- ☐ reaching overhead
- ☐ lifting objects
- ☐ playing a sport
- ☐ repetitive activities
- ☐ standing
- ☐ bending forward
- ☐ sleeping
- ☐ coughing/sneezing
- ☐ turning/twisting body
- ☐ sustained movements
- ☐ stress
- ☐ other_____

Does anything relieve your symptoms? Please explain:

HISTORY OF PRESENT CONDITION (continued)

Have you had any previous treatment or tests for this condition? (select all that apply)

- ☐ physical therapy
- ☐ massage therapy
- ☐ chiropractic care
- ☐ traction
- ☐ acupuncture
- ☐ x-ray
- ☐ MRI
- ☐ CT scan
- ☐ EMG
- ☐ bone scan
- ☐ exercise
- ☐ home health
- ☐ casting
- ☐ bracing
- ☐ medication
- ☐ injection
- ☐ bed rest
- ☐ hospitalization
- ☐ other

Since your symptoms began, have you had any of the following?

- ☐ bowel or bladder issues
- ☐ weakness
- ☐ dizziness or fainting
- ☐ fever/chills/sweats
- ☐ significant weight change
- ☐ hearing or vision problems
- ☐ numbness or tingling
- ☐ difficulty swallowing
- ☐ pain at night
- ☐ numbness in the anal or genital area
- ☐ vague feeling of bodily discomfort
- ☐ NONE

Are you currently able to perform all of your regular work/home duties? If no, please list activities that you are not able to do:_____

SOCIAL LIFE

In general, would you say your overall health is:

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor

Do you exercise regularly? ___Yes ____No

If yes, please describe:

Do you smoke? _____packs/_____day/week
☐ Yes ☐No

Do you drink alcohol? _____drinks/_____day/week
☐ Yes ☐No

Occupation:_____

- ☐ Full-time
- ☐ Part-time
- ☐ Student
- ☐ Retired
- ☐ Other _____

Does your job include any of the following?
☐ sitting ☐ standing ☐ lifting

What is your current living situation? (choose all that apply):

Live with: _____
Type of residence _____
Stairs: _____
Assistance: _____

PAST MEDICAL HISTORY

Do you currently have or have you had a history of any of the following? (select all that apply)

- ☐ Diabetes
- ☐ High blood pressure
- ☐ Cancer/Tumor
- ☐ IBD (Crohn's, UC)
- ☐ Anemia
- ☐ Stroke
- ☐ Osteoporosis
- ☐ Nausea/Vomiting
- ☐ Cardiac arrhythmias
- ☐ Pacemaker
- ☐ Blood clots
- ☐ Peripheral Vascular Disease
- ☐ Bruising easily
- ☐ Neurological conditions
- ☐ Sleep disorder
- ☐ Seizures/Epilepsy
- ☐ Thyroid problems
- ☐ Pulmonary conditions
- ☐ Multiple Sclerosis
- ☐ Kidney problems
- ☐ Parkinson's disease
- ☐ Fractures
- ☐ Joint replacement
- ☐ Arthritis/Swollen joints
- ☐ Rheumatoid arthritis
- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Gout
- ☐ Headaches/Migraines
- ☐ Dizziness/Vertigo
- ☐ Loss of balance/Falls
- ☐ Shortness of breath
- ☐ Infectious disease
- ☐ Use of steroids/inhalants
- ☐ Currently pregnant
- ☐ Depression
- ☐ Chemical dependency
- ☐ Sensitivity to heat/ice
- ☐ Allergy to adhesive/tape/ lotions
- ☐ Angina
- ☐ Coronary Artery Disease
- ☐ Other_____

_____

Please list any PREVIOUS surgeries:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____

MEDICATIONS

Are you allergic to any medications? (YES/NO)_____ If YES, what?_____

Please list ALL medications you are taking at present:

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 while a patient at CompassionFirst Rehab Services LLC.

Patient Name and Signature:_____