WANTAGE
PHYSICAL
REHABILITATION

Ph. : (973) 875-1974
Fax : (973) 875-1984

359 Route 23 North,
Sussex, NJ 07461

wantagerehab.com
wantagerehab@gmail.com

PATIENT INFORMATION – *all information is REQUIRED*

Name _____Date of Birth ____ / ____ / _____Soc.Sec.#_____ - ____ - _____

Address _____City _____ State _____ Zip _____

Home Phone _____-_____- _____ Cell Phone _____-_____-_____Employer_____

Work Phone _____-_____ - _____ Email Address _____
How would like your appointments confirmed? ☐ Text ☐ Email ☐ Voicemail

In case of emergency, who should we contact? _____Phone _____-_____- _____

PRIMARY INSURANCE

Insurance Name_____Phone #_____-_____-_____ Fax #_____-_____-_____

Insured Name _____Relationship to Patient _____

Insured Date of Birth ____ / ____ / _____ Insured Soc. Sec. # _____ - ____ - _____

ID # _____If auto or work accident, Claim # _____

SECONDARY INSURANCE

Insurance Name_____Phone # _____-_____-_____Fax #_____-_____- _____

Insured Name _____ Relationship to Patient _____

Insured Date of Birth ____ / ____ / _____ ID # _____ Group # _____

REFERRING PHYSICIAN

Name _____Phone # _____-_____-_____Fax #_____-_____- _____

Physician Address _____ City _____ State _____ Zip _____

ACCIDENT INFORMATION – *PLEASE PROVIDE POLICE REPORT IF AUTO ACCIDENT*

Type of accident: ☐ Work / ☐ Auto (☐ Driver / ☐ Passenger / ☐ Pedestrian) Injury Date ____ / ____ / _____

Where did accident occur (City, State) _____ Emergency Room: ☐ Yes / ☐ No

ATTORNEY INFORMATION

Name_____Phone #_____-_____-_____Fax #_____-_____ - _____

Address _____ City _____ State _____ Zip _____

SIGNATURE

I acknowledge receipt of the "**Notice of Privacy Practices**", which I have received at the time of this evaluation or previously.

_____ _____
Patient's Signature Date

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To ensure you receive a complete and thorough evaluation, please provide us with important background information. Please answer each question as accurately and as completely as you can. If you do not understand a question, please as for assitance .

History of *Present* Condition

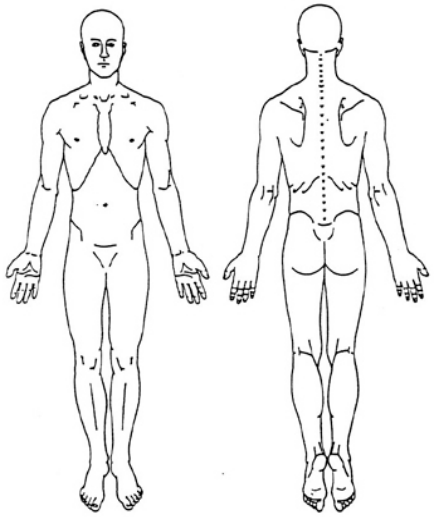
What are your symptoms?

_____

_____

_____

On the body diagram below, please indicate where your pain is located at the present time.



How would you rate the intensity of your pain on the scale below? *Check a number.*

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

0 no pain 1 2 little 3 4 moderate 5 6 quite bad 7 8 severe 9 10 unbearable pain

When did your symptoms begin? *(Approx. date)*

_____

Which of the following BEST DESCRIBES how your injury occurred? *Check one*

☐ Lifting
☐ Work Injury
☐ A Fall
☐ Trauma
☐ Running
☐ Other _____
☐ MVA (Car Accident)
☐ During sports/recreation
☐ Overuse
☐ Degenerative process
☐ Unknown

Since onset are your symptoms getting:
☐ Better ☐ Worse ☐ Not Changing

Have you had similar symptoms in the past?
☐ Yes ☐ No

As the day progresses, do your symptoms:
☐ Increase ☐ Decrease ☐ Stay the same

Nature of your pain: *Check all that apply*
☐ Sharp ☐ Pins/Needles ☐ Radiating
☐ Throbbing ☐ Dull ☐ Numbness
☐ Aching ☐ Stabbing ☐ Burning
☐ Tingling ☐ Other_____

Is your pain:
☐ Constant ☐ Occasional / Intermittent

Does the pain wake you at night?
☐ Yes ☐ No

If yes, is it present…*Check one*
☐ While lying still
☐ When changing positions
☐ Both

What aggravates your symptoms? *Check all that apply*
☐ Sitting ☐ Going to/rising from sitting
☐ Lying down ☐ Walking
☐ Up/Down stairs ☐ Bending forward/backward
☐ Overhead ☐ Reaching behind back
☐ Standing ☐ Reaching in front of body
☐ Squatting ☐ Reaching across body
☐ Sleeping ☐ Coughing/Sneezing
☐ Stress ☐Taking a deep breath
☐Other_____

What relieves your symptoms? *Check all that apply*
☐ Sitting ☐ Stretching
☐ Heat ☐ Ice
☐ Rest ☐ Standing
☐ Walking ☐ Exercise
☐ Massage ☐ Medication
☐ Lying down ☐ Nothing
☐ Other_____

Have you had any previous treatment for this condition?
Check all that apply
☐ None
☐ Medication (oral)
☐ Massage therapy
☐Chiropractic_____
☐ Family Care Doctor_____
☐ Physical Therapy _____
☐ Specialist_____(type of specialty)

Have you had any of the following tests?
☐ X-Rays
*Date/Location*_____

☐ CT Scan
*Date/Location*_____

☐ MRI
*Date/Location*_____

☐ Other _____
☐ None

⇨ Turn Over

Medications

Please list any prescription medications you are currently taking. *(Pain pills, injections, skin patches)*

_____
_____
_____
_____
_____
_____
_____
_____

Are you currently taking any of the following over the counter medication? *Check all that apply*

☐ Aspirin ☐ Tylenol
☐ Corticosteroids ☐ Advil/Motrin/Ibuprofen
☐ Antihistamines ☐ Vitamins/Mineral Supplements
☐ Other _____

Height _____ft _____ in. **Weight** _____

How would you rate your general health?
☐ Excellent ☐ Average
☐ Good ☐ Fair
☐ Poor

Do you exercise outside of normal daily activities?
☐ 5+ days/wk ☐ 3-4 days/wk
☐ 1-2 days/wk ☐ Occasionally
☐ Zero
Exercise, Sports/Recreation consist of:
_____
_____
_____

Do you drink caffeinated beverages?
☐ No ☐ Yes
If yes, how many per day?
_____

Do you smoke?
☐ No ☐ Yes
If yes, how many packs per day?
_____

What is your stress level?
☐ Low ☐ Medium ☐ High

For Females: Is there a possibility you may be pregnant?
☐ No ☐ Yes

Are you currently seeing any other health care providers other than the physical therapist?
_____
_____
_____

Past Medical History

Have you ever been diagnosed with any of the following conditions? *Check all that apply*

☐ Cancer ☐ Multiple Sclerosis
☐ Depression ☐ High Blood Pressure
☐ Arthritis ☐ Kidney Problems
☐ Asthma ☐ Blood Disorders
☐ Head Injury ☐ Parkinson's Disease
☐ Osteoporosis ☐ Stomach Problems
☐ Diabetes ☐ Circulation/Vascular Problems
☐ Stroke ☐ Epilepsy/Seizures
☐ Heart Problems ☐ Infectious Disease
☐ Broken Bone ☐ Thyroid Problems
☐ Allergies _____
☐ Other _____

Surgical History

Please list any past surgeries/ procedures you have had along with the date.

Surgery **Date**
_____
_____
_____
_____
_____

Family History

Has anyone in your immediate family (parents, siblings) ever been treated for any of the following?

☐ Diabetes ☐ Cancer
☐ Heart Disease ☐ Arthritis
☐ Osteoporosis ☐ High Blood Pressure
☐ Stroke ☐ Psychological Condition
☐ Other _____

Work History

Occupation:
_____

☐ Full Time ☐ Part Time
☐ Self Employed ☐ Retired
☐ Student ☐ Homemaker
☐ Unemployed ☐ Other _____

Physical Activities at work *Check all that apply*
☐ Sitting ☐ Standing
☐ Phone Use ☐ Repetitive Lifting
☐ Computer Use ☐ Heavy Lifting
☐ Driving ☐ Heavy Equipment Operation
☐Other_____

Are you currently receiving or seeking disability benefits for this condition?
☐ Yes ☐ No

Signature_____ **Date** _____/_____/_____

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We welcome you to the practice and being a partner in improving your health and quality of life.

Consent for care and treatment: I do hereby agree and give my consent to Wantage Physical Rehabilitation to furnish medical care and treatment considered necessary and proper in diagnosing or treating his/her physical condition.

Benefits release of information: I do hereby assign all major medical benefits to which I am entitled, including but not limited to, Medicare, private insurances and third-party payers to Wantage Physical rehabilitation. A photocopy of this ***insurance card*** provided by me during the first visit is considered as valid as the original. I hereby authorize said assignee to release all information necessary, including but not limited to medical records, for treatment and to secure payments. If there is ***change in the insurance*** while am in the care it's your responsibility to provide the updated copy of insurance card and provide the effective date for the new insurance policy. If any of the insurance details provided are wrong- I understand that the medical office cannot secure payment for the services rendered and hence it will be patient's responsibility.

Financial Policy Statement: As a courtesy we will make every attempt to contact your insurance carrier prior to your first visit for specifics on your responsibility, i.e deductible, co-insurance, co pay and bill your treatment charges to your insurance carrier. If, However, when the explanation of benefits/payment is received from your insurance carrier which is contrary to information received previously you are obligated to that explanation. Also – *co pay, co insurances and deductible* are patient's responsibility within the discretion to your insurance plan. If you have no insurance and wish to pay out of pocket, you are responsible for the entire bill when the services are rendered. If your insurance carrier does not remit payment within 60 days of submission, the balance will be due in full of you at which time we will provide billing information for you to forward on. If your insurance company requests a refund of payments made, you will be responsible for that amount of money.

If any payment is made directly to you for the services billed by us, you recognize an obligation to promptly remit same to Wantage Physical Rehabilitation

I hereby authorize and guarantee payment for all services rendered. Although fees for services are due and payment expected at the time of services are rendered, if I have been granted a grace period of payment of fees, I acknowledge that payment is due and expected at the time the billing statement is received. In the event my account becomes delinquent for more than 30 days, I agree to pay all reasonable collection costs not to exceed 75% court costs, attorney costs and interest fees accrued with the collection of this account.

Special Notes regarding PIP, Motor Vehicle, Worker's Compensation: **Personal injury cases** are handled in the same manner. Please be aware that for standard PIP coverage, there is a $250 deductible and 20% co-insurance until $5000 and the limit on medical expenses is $250,000. If your plan is different, it is your responsibility to know what your portion is. **Auto insurance policies** have changed a lot over the past few years and so did the coverage. Having an attorney does not mean that you are always covered for medical expenses. Please provide the correct information of the adjuster and contact no during the first visit. Please note that if the claim is disputed or denied for any reason, you are fully responsible for the balance. **Workers Compensation**: Please provide ***the correct information of the adjuster and contact no*** during the first visit. We are in contract with major workers compensation insurance, which ensures coverage of services. If there is a lack of information from you and the office is unable to bill for the services rendered- it's your responsibility to pay in full.

Missed or Cancelled Appointments: As a courtesy to all our patients, we require a 24-hour advance notification for all cancellations. A $30 fee would be assessed to No Show Appointments. Advance notice allows someone else to reserve that time that was set aside for you. Please be courteous and responsible. This fee is not billable to the insurances.

No show policy: All cancellations and no-shows will be documented in your medical record and appropriately reported to your physician and insurance/third party payor. A lot of major medical insurance requires you to keep up with the plan of care (frequency of visits/week and no weeks) established by your licensed Physical Therapy provider and you. Since the authorizations are approved based on the date range – it is important to communicate and establish the plan of care on

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the first visit. Also, it's extremely important to *keep up the plan of care established during treatment in Wantage Physical Rehabilitation. This helps in improvement in your condition and ensuring the proper reporting to the insurance. For Worker's Compensation and Personal Injury patient's documents of any missed or cancelled appointments are forwarded to your case manager and primary care doctor. This could jeopardize your claim and prolong or stop any benefits you may be entitled to. Please do not cancel appointment if you are feeling worse and believe the treatment is not working. Keep your appointment and discuss any changes with your licensed Physical Therapy provider. Please understand that your pain will probably fluctuate as your course of treatment progresses. Please do not cancel if you are feeling better. Keep your appointment to progress your plan and prepare for discharge. When you don't show as scheduled, three people are hurt. You, because you don't get the treatment you need; the physical therapist, who now has a space in his/her schedule since the time was reserved for you personally; and another patient who could have been scheduled for treatment if you had given proper notice. All the staff at Wantage Physical Rehabilitation appreciate your anticipated adherence and cooperation with this policy. We are here to help you attain all your goals and optimize your return to all your pre-injury activities. We appreciate the opportunity to provide you with uncompromising care. Thank you for your consideration of our staff and other patients.

During the Rx visits: we use a variety of procedures and modalities to help the pain and improve the function. As with all medical treatments – there is risk and benefit involved with Physical Therapy**.** We are not able to guarantee precisely what your reaction to a particular treatment might be, although we use the best of our knowledge and evidence-based practice to ensure the highest level of care. You understand that it's rare to have complications with the treatments performed but there is a possibility of it. We offer patient centric tailored programs to help you recover. You may feel sore, there may be ups and downs in the aches throughout the course of treatment. To understand better - Please talk to your provider at the Wantage Physical rehabilitation.

We look forward to building a successful relationship with you ! I have read, understand, and agree to these policies.

_____ _____

Signature of Patient/ Guardian Date