Phone (732) 353-6335
Fax (732) 254-1533
*to talk to the people who care about you*

# East Brunswick Physical Therapy, LLC

Williamsburg Commons
3-A & B Auer Court
East Brunswick, NJ 08816

## PATIENT INFORMATION

Please complete all of the following information thoroughly:

Name: _____
Last, First Middle Occupation

Address: _____
Street/PO Box City State Zip

Residence if different from above: _____
Street/PO Box City State Zip

( )_____ ( )_____ ( )_____
Home Phone Work Phone Cell Phone

_____
Date of Birth Age Sex Social Security# Email Address

_____
Nearest Relative / Emergency Contact Phone # How did you hear about us?

Work Information: _____
Name Address Phone

Referring Physician: _____
Name Phone

If Party is a minor: _____
Name of Insured Parent Social of Insured Parent DOB

Diagnosis: _____ Date of Injury _____

Circle YES or NO

1. Is this condition related to an injury on the job? Yes No
   If Yes, please provide workers compensation information below
2. Is this injury related to a Motor Vehicle Accident? Yes No
   If yes, please provide your auto insurance information below
3. Is this injury involved or will be involved in litigation? Yes No
   If yes, phase provide attorney information below

Yes answers: _____

_____

I authorize East Brunswick PT to release and request information to/from insurance companies and all medical providers.
I authorize assignment of benefits directly to this clinic.

Parent or Guardian Signature _____ Date _____

## Other Clinical Tests

Within the past year have you had any of the following tests?

(Please circle all that apply)

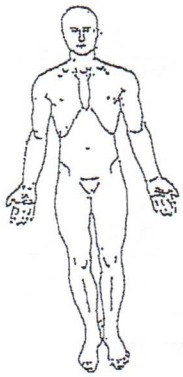
| | | |
|---|---|---|
| Angiogram | EEG (electroencephalogram) | Pulmonary function test |
| Arthroscopy | EKG (electrocardiogram) | Spinal Tap |
| Biopsy | EMG (electromyogram) | Stress Test |
| Ultrasound | Bone Scan | MRI |
| X Ray | CT Scan | Myelogram |

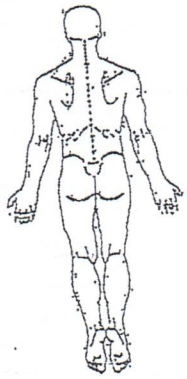
Venous Doppler Test

**We may request from your physician any reports indicated above and other information that would be helpful in the course of your treatment**

## Patient Symptoms Drawing

Please draw on the body where you feel your pain or problems:





Please indicate what kind of symptoms you are having, circle all that apply:

| | | | |
|---|---|---|---|
| Tingling | Numbness | Sharp | Dull |
| Ache | Tight | Weak | |

Please indicate Yes or No:

Yes No Have you ever taken steroid medication such as cortisone?

Yes No Have you ever been placed in a cast, splint, ace wrap, or sling for this injury?

Yes No Are you currently being treated or have been treated in the current year by any other physical therapist, massage therapist, podiatrist, or chiropractor?

Tiffany Pulcio, PT, MS
Call 732-254-CARE (2273)
*to talk to the people who care about you*

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## Informed Consent for Physical Therapy Services

The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis, and intervention by the use of rehabilitative procedures, mobilization, massage, exercises and physical agents to aid the patient in achieving their maximum potential within their capabilities, and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

Response to physical therapy intervention varies from person to person, hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. East Brunswick Physical Therapy does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeing treatment for. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury. It is very important to communicate with your treating physical therapist throughout your treatment.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care. I authorize the release of my medical information to appropriate third parties.

Patient Name:_____ Signature_____ Date:_____

Patient Acknowledgement Form

Notice of Privacy Practices

I have been provided with a copy of East Brunswick Physical Therapy's Notice of Privacy Practices, which describes East Brunswick Physical Therapy's use and disclosure of my Protected Health Information (PHI)

Patient Name: _____

Patient Signature: _____

Date: _____

*New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations*

The Healthcare Insurance Portability and Accountability act of 1996 ("HIPPA") is a federal program, which requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

We are required by law to maintain the privacy of your protect health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service.

I understand and have been provided, (see brochure at front desk), with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. If I have any further questions in regards to the Privacy Practices I can contact the privacy officer.

I understand that CPPT, Inc. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that CPPT, Inc reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should CPPT, Inc change their notice, they will send a copy of any revised notice to the address I have provided.

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

Ok to speak with: _____

I understand that as part of CPPT, Inc treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including via fax.
I fully understand and accept the terms of this consent

_____ _____

Patients Signature Date

*I have attempted to obtain the patient's signature in Acknowledgment of this notice of Privacy Practices, but was unable to do so as indicated: Date:_____ Initials:_____ Reason:_____*

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## ASSIGNMENT OF BENEFITS

Policy# _____

Patient's Name _____

I authorize and request _____ insurance company to pay directly to the above named medical provider, the amount due to me under the terms of the above-referenced policy as a result of medical care rendered by the medical provider and all medical staff associated with the provider's office.

Patient's Signature or Parent/Legal Guardian _____ Date _____

Provider's Signature _____ Date _____