PATIENT INFORMATION

Date: _____

Last Name: _____ First Name: _____ M: ___

Sex: ☐ Male ☐ Female Date of Birth: _____ Social Security #: _____

Marital Status: _____ Preferred Language: ☐ English / Other _____

Address: _____ City: _____ State/Zip: _____

Home Phone # _____ Cell Phone # _____ Work Phone# _____

Email Address: _____ Preferred Contact: Home / Cell / Work / E-Mail (circle one)

Referring Doctor: _____ Primary Doctor: _____

Employer/School: _____ Occupation: _____

Emergency Contact: _____ Phone Number _____

Primary Insurance Information

Type: ☐ Health Insurance ☐ Workers Comp ☐ Motor Vehicle ☐ None/Self-Pay

Subscriber's Name: _____ Date of Birth: _____

Address: _____ SS ID #: _____

Insurance Company: _____ Date of Accident: _____

Address: _____ Phone #: _____

Group/Claim #: _____ Policy/ID #: _____

Adjustor: _____ Phone #: _____

Attorney Info: _____ Phone #: _____

Secondary Insurance Information

Type: ☐ Health Insurance ☐ Workers Comp ☐ Motor Vehicle ☐ None/Self-Pay

Subscriber's Name: _____ Date of Birth: _____

Address: _____ SSID #: _____

Insurance Company: _____ Date of Accident: _____

Address: _____ Phone #: _____

Group/Claim #: _____ Policy/ID #: _____

Chief Complaint: _____

Is your pain from an Auto or Worker's Comp Accident? ☐ YES ☐ NO

Initial Pain Level (1-10, 10 being worst) ____ How often do you feel the pain? ☐ Occasional ☐ Frequent ☐ Constant

What makes symptoms worse? ☐ Walking ☐ Standing ☐ Sitting ☐ Lying Down

What makes symptoms better? ☐ Walking ☐ Standing ☐ Sitting ☐ Lying Down

Medical History

Patient's Medical History:

Allergies ☐YES ☐NO
Diabetes ☐ YES ☐ NO
Blood Pressure ☐ YES ☐ NO
Asthma/COPD ☐ YES ☐ NO
Stroke ☐ YES ☐ NO
Heart Problems ☐ YES ☐ NO
Kidney Problems ☐ YES ☐ NO
Seizure Disorders ☐ YES ☐ NO
Bleeding/Clotting ☐ YES ☐ NO
Liver/Hepatitis ☐ YES ☐ NO
Sleep Apnea ☐ YES ☐ NO
Cancer ☐ YES ☐ NO
Thyroid ☐ YES ☐ NO

Previous Hospitalizations/Surgeries

_____
_____
_____
_____
_____

Current Medications

_____
_____
_____
_____
_____
_____

Family Medical History, If Pertinent

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Children	_____	_____	_____

Previous Treatment? Please check any of the following that applies to you:

☐ Physical Therapy ☐ Chiropractic Therapy ☐Anti-Inflammatory Meds
☐ Nerve Blocks/Injections ☐ Epidural Injections ☐ Home Exercises/Self Care/Ice/Heat

Radiological Imaging?

☐ MRI For what body part? _____ ☐ CT scan For what body part? _____
☐ XR For what body part? _____ ☐ EMG For what body part? _____

ASSIGNMENT OF BENEFITS

Patient Name: _____

I, irrevocably assign to Jersey Rehab, P.A. all my rights and benefits under any insurance contracts for payment of services rendered too me by Jersey Rehab, P.A. I irrevocably authorize Jersey Rehab, P.A. to file insurance claims on my behalf for services rendered to me.

Jersey Rehab, P.A. has made me aware that all claims will be submitted to my insurance carrier if provided. Any co-pay, co-insurance and deductible will be my responsibility. All payments are to be directed to Jersey Rehab, P.A. There will be 3 attempts by Jersey Rehab, P.A. to collect any debt. If Jersey Rehab, P.A. is unsuccessful in collecting your debt, it will be handed over to a representative for suit. I understand that it is my responsibility to inform Jersey Rehab, P.A. of any insurance change to my current policy or change in insurance company and if I do not do so, I will be fully responsible for all bills incurred within that period.

This Assignment of Benefits has been explained to my full satisfaction and I understand its nature and effect. I hereby authorize photocopies of this form to be valid as the original.

WAIVER

I, _____, understand that my insurance company may not cover certain procedures and supplies that are necessary for my treatment. I understand that I am responsible for charges that I incur during my treatment(s) which are not covered by my insurance company.

I will make payments, if necessary, as discussed and agreed upon with Jersey Rehab, P.A.

HIPPA

I, _____, acknowledge receipt of Jersey Rehab's Notice of Privacy Practices.

_____
Signature

_____ _____
Printed Name Date

No Show Policy

UPDATED

MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Jersey Rehab, P.A. When you schedule an appointment with Jersey Rehab, P.A. we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

Please see our Appointment Cancellation/No Show Policy below:

Effective November 1, 2022, any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours' notice** will be considered a No Show and charged a **$50.00 fee.**

The fee is charged to the patient, not the insurance company, and is **due at the time of the patient's next office visit.**

You may contact Jersey Rehab, P.A. 7 days a week , 24 hours a day @ 973-844-9220. Should it it be after regular business hours Monday through Friday, or a weekend, you may leave a message.

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

_____

Signature

_____ _____

Printed Name Date

Credit Card on File Policy

At Jersey Rehab, we require keeping your credit card or debit card on file as a convenient method of payment for the portion of services that your insurance does not cover, but for which you are liable. Without this authorization, a billing fee of $_____ will be added to your account for any balances that we must attempt to collect through mailing a monthly statement. Furthermore, an "outstanding balance" charge of 1.5% of the total bill will be charged for each month that the bill remains unpaid.

Your credit card information is kept confidential and secure. Payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has been paid and posted to the account.

I authorized Jersey Rehab to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐ AMEX ☐ VISA ☐ Mastercard ☐ Discover

Credit Card Number: _____

Expiration Date: _____/_____/_____ CVC: _____

Cardholder Name: _____

Signature: _____

I, (we), the undersigned, authorized and request Jersey Rehab to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by Jersey Rehab. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60-day notification to Jersey Rehab in writing and the account must be in good standing.

_____
Signature

_____ _____
Printed Name Date