SMART MOVE
PHYSICAL THERAPY

1675 Whitehorse Mercerville Rd,
suite 101, Hamilton Township, NJ 08619

PERSONAL INFORMATION

Name: ____
(Last) (First) (Middle)

Gender: ☐ Male ☐ Female ☐ Other Date of Birth (DOB):__/__/_____ Marital Status: __________

Address: ____
(City, State, Zip Code)

Phone No: ______________________ Cell No: ______________________

EMERGENCY CONTACT

Name: ____

Relation to the Patient: __________ Emergency Phone Number: ______________

MAJOR INSURANCE INFORMATION

Primary Insurance

Health Insurance Name: ____

Policy Holders Name: ______________________________ Relation: __________

Policy Holders (DOB): ___/____/_____ Insurance ID/ Member ID #: ______________

Social Security #: ____

Secondary Insurance (If Applicable)

Health Insurance Name: ______________________ Relation: ______________

Policy Holders Name: ______________________ Policy Holders DOB: __________

Insurance ID/ Member ID #: ______________________ Social Security #: __________

Is this a Workers Compensation case (WC)-?

☐ Yes ☐ No

Is this a No – Fault case (NF)-?

☐ Yes ☐ No

I, ______________________, Hereby acknowledge that I have provided accurate information to the best of my knowledge. I consent to receive physical therapy treatment from **Smart Move Physical Therapy**.

Signature: ______________ Date: ______________

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PATIENT MEDICAL HISTORY

Please describe your Problem/Major complain: ______________________________

Date of onset: ______________________________

How would you describe your pain?

Shooting ☐ Intermittent ☐ Night Pain ☐ Constant ☐ Sharp

Occasional ☐ Numbness ☐ Tingling ☐ Burning

Please rate your pain level from 0 - 10: **1 2 3 4 5 6 7 8 9 10**

Any falls or accidents in the past year ☐ Yes ☐ No How many falls? __________

Have you had any of the following diagnostic tests relating to this injury? (mark all that apply)

X-Ray ☐ MRI ☐ CT Scan ☐ Ultrasound ☐ EMG/NCV Other: __________

Please list ALL medication you are currently taking: ______________________________

Please list any Major Surgeries and Hospitalizations

______________________________ Date: __________

______________________________ Date: __________

Do you Smoke? ☐ Yes ☐ No Are you Pregnant? ☐ Yes ☐ No

Allergies if any: ______________________________

Have you received prior Physical Therapy services for this problem this year? ☐ Yes ☐ No

If No, Have you received Physical Therapy services this year for anything else? ☐ Yes ☐ No

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Pre-existing Medical Conditions (Check all that apply)

☐ Anxiety ☐ Arthritis ☐ Angina ☐ Asthma ☐ GI problems ☐ Heart Attacks ☐ Stroke

☐ Cardiac Disease/Conditions ☐ Cardiac Pacemaker/ Defibrillator/ Stent ☐ Circulation Problems

☐ Circulation Problems ☐ Diabetes ☐ High Blood Pressure ☐ Tumor ☐ Depression ☐ COPD

☐ Epilepsy ☐ osteoporosis ☐ Kidney Diseases ☐ Gout ☐ Lung Diseases ☐ Cancer

☐ Fractures (broken bones) ☐ Hernia ☐ Firbomyalgia ☐ Metal implants

Please mark the following if you have recently experienced

☐ Headaches ☐ Migraine ☐ Dizziness/ringing in ear/vertigo ☐ Incontinence ☐ Tremors

☐ Difficulty Sleeping ☐ Unexplained Weight Loss ☐ Shortness of Breath ☐ Lyme Disease

☐ Unusual Fatigue/Weakness ☐ Pain with Coughing/Sneezing ☐ Balance problems

☐ Rheumatoid Arthritis

Have you suffered from any illness not listed here? ☐ Yes ☐ No

If yes please explain ____

I ______________________ have provided all of the above information to the best of my knowledge at the time of this visit and will notify this office if any information above has changed during the care of **Smart Move Physical Therapy**.

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CONSENT AND DISCLOSURE

1 Notice of Privacy Practices

I, ______________________________ hereby authorize **Smart Move Physical Therapy, LLC** to use and disclose my protected health information (PHI) for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

I acknowledge that I have been offered a copy of the Notice of Privacy Practices from **Smart Move Physical Therapy, LLC** and have had the opportunity to review it. This notice is prominently displayed within the clinic premises and is also accessible on our website.

I understand that my PHI may be used for treatment: Including, but not limited to, sharing information with healthcare professionals involved in my care.

I understand that my PHI may be used for payment and I consent to the release of information and/ or disclosure to **Smart Move Physical Therapy, LLC** of all or any part of my medical record to other health care providers involved in my care or third-party payers as is necessary for processing claims.

I understand that I have the right to revoke this authorization at any time, except to the extent that action has already been taken in reliance on it.

I understand that revocation must be made in writing and submitted to **Smart Move Physical Therapy, LLC.**

I acknowledge that details regarding medical history and appointment reminders, including date and time, may be communicated via my answering machine, email, and/or received through a text message.

I consent to Smart Move PT, LLC releasing my protected health information and billing concerns to the following individuals.

Name: ______________________________ **Relationship to patient:** ______________________________

Name: ______________________________ **Relationship to patient:** ______________________________

2 Consent to Treat

I agree to undergo evaluation and receive treatment from **Smart Move Physical Therapy, LLC** in accordance with a predetermined plan of care. I affirm that I have been adequately informed and have actively participated in the planning of the care and procedures to be administered by **Smart Move Physical Therapy LLC** and sign this consent form willingly and voluntarily.

3 I hereby authorize payment to **Smart Move Physical Therapy, LLC** for all physical therapy services provided. Additionally, I acknowledge and accept that regardless of my insurance coverage, I am personally liable for any outstanding balance on my account for professional services received.

4 I am aware my child is receiving Physical/Occupational Therapy at **Smart Move Physical Therapy.** I am unable to attend his/her office visits. Please accept this form as my consent to treat my child.

Parent/Guardian initials if applicable : ______________________________

I have read and fully understand the above consents and disclosures

Patient Signature: ______________________________

Parent/Guardian/, Representative Name: ______________________________ Signature: ______________________________

Relationship to Patient: ______________________________ Date: ______________________________

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GENERAL OFFICE POLICIES

1 Cancellation Policy

We require 24 hours notice in the event of a cancellation.If a no call is received/documented your visit will be counted as a **"NO SHOW."**

2 Cancellation or No Show Fee

Patients may be subject to a $45 fee for both NO SHOW appointments and cancellations made without providing at least 24 hours' notice.

3 Payment Policies

Patients may be required to pay copayments, deductibles, or any outstanding balances at the time of service. Accepted payment methods should be clearly communicated.

4 Insurance Verification

Smart Move PT verifies patient benefits with your insurance carrier as a courtesy to the patient. Benefits quoted are not a guarantee of payment. Patient is ultimately responsible for any denied services rendered at **Smart Move PT**.

5 Treatment Of Minors

In the event of minors receiving treatment, parents/guardians have been advised to stay on the premises throughout the treatment session. I waive any claims that may arise from their failure to do so. Should a parent choose to depart, they must provide consent by signing a form.

After you have read carefully the above, please sign the following:

I ______________________________ , agree to be treated in this Physical Therapy clinic by the Physical Therapist and their staff and I also agree with the terms specified above.

Signature: ___________________________ Date: ______________________________

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WORKERS COMPENSATION

Date of Accident: _____/ _____/_______

Workers Compensation Carrier Name: ____

Case/ Claim #: ____

Name of Adjuster/Case Manager: ____

Phone #: ____________________________ Fax #: ____________________________

Employer Name: ____

Phone #: ____________________________ Fax #: ____________________________

Address: ____

Attorney Name: ____

Phone #: ____________________________ Fax #: ____________________________

Address: ____

AUTHORIZATION AND CONSENT

I, the undersigned, hereby authorize and request the provision of physical therapy services as described above for the treatment of my work-related injury or condition. I understand that the information provided in this form will be used for the purpose of processing my workers' compensation claim and coordinating my treatment. I understand that I am financially responsible for all charges whether or not paid by insurance.

Patient Signature: ____________________________ Date: ____________