SOAR Physical Therapy & Acupuncture

2123 Route 35, Sea Girt, NJ • Phone 732-449-2001 • Fax 732-449-2238 • soarpt.com

# Administrative Intake Sheet

Patient Name: _____
(Last) (First) (M.I.)

Birthdate: _____ Gender: ☐ Male ☐ Female

Street Address: _____
City: _____State: _____ Zip: _____

1st Preferred Phone #: _____ (☐ Home ☐ Work ☐ Mobile)
2nd Preferred Phone #: _____ (☐ Home ☐ Work ☐ Mobile)
3rd Preferred Phone #: _____ (☐ Home ☐ Work ☐ Mobile)
E-Mail: _____

How Did You Choose Our Practice?
☐ I Was a Previous Patient ☐ Word of Mouth ☐ Our Web Page ☐ Facebook ☐ YELP!
☐ Google/Search Engine ☐ Newspaper Ad ☐ Managed Care Network ☐ Yellow Pages
☐ Doctor Recommended ☐ SOAR Education Seminar
☐ Other _____

Who Can We Thank For Referring You?_____

Occupation: _____☐ Full-Time ☐ Part-Time
Currently Working: ☐ Yes ☐ No ☐ Full-Time ☐ Part-Time ☐ Light Duty

Any Referring Physician: _____
Their Address & Phone: _____
Next Follow-Up Appointment Date: _____
*Please advise us of future doctor appointments so we can provide progress reports.*

Primary Physician (if different than referring):_____
Their Address & Phone: _____

Surgeon (if different than referring):_____
Their Address & Phone: _____

Any Case Manager: _____
Their Address & Phone: _____

Emergency Contact Name & Phone: _____

**Please give the following items to the receptionist so we can make a copy for your file:**
a) Driver License (preferred) or other Photo ID – if patient is a minor, provide parent/guardian's
b) All Insurance Cards (please advise which is primary vs. secondary)
c) Credit Card (for our use only if you fail to pay a balance that is outstanding for 30 days.)
d) Any prescription you may have been given by your physician

Policy Holder's Name: (□ Same as Patient) _____
Policy Holder's Address: (□ Same as Patient) _____
Policy Holder's Phone: (□ Same as Patient) _____
Policy Holder's Birthdate: (□ Same as Patient) _____
Policy Holder's Gender: □ Male □ Female
Policy Holder's Employer: _____
Patient's Relationship to Policy Holder: □ Self □ Spouse □ Child □ Other _____
_____
If child, address & phone of non-policy holder parent: (□ Same as Patient) _____
_____

Payment Guarantor (□ Same as Patient) _____
Their credit card billing address & phone: _____
_____

Is this problem:

Related to an Auto Accident or Injury? □ Yes □ No
Related to a Work Accident or Injury? □ Yes □ No
Related to Another Type of Accident? □ Yes □ No_____
Is there Litigation related to this accident? □ Yes □ No

**Please initial your acknowledgement of each of the following:**

_____ I have received and signed a copy of SOAR's "Financial Policies".

_____ I have read and had any questions answered about SOAR's "Credit Card Authorization" Policy".

_____ **MEDICARE NOTICE**: If you have an "open case" for ***any*** Medicare covered home services and that case remains open on the same day you are seen here, your visit(s) here will NOT be covered and you will be responsible for 100% of the physical therapy fees. Outpatient physical and speech therapies have a combined annual dollar reporting threshold by Medicare. We will keep track of your expenses for you but you MUST advise us of all PT & Speech Therapy expenses by other providers in this same calendar year. Otherwise, you may be responsible for your expenses that exceed the threshold.

Signature: _____ Date: _____
Patient (Parent or Guardian if patient is a minor)

Witness: _____ Date: _____

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# Clinical Intake Sheet

Patient Name: _____
(Last) (First) (M.I.)

Birthdate: _____ Gender: ☐ Male ☐ Female

**Periodically, we provide clinical internship training for students. Please indicate your preference:**
☐ I am willing to be treated by a physical therapy intern under the supervision of a S.O.A.R. physical therapist.
☐ I am not willing to be treated by a physical therapy intern under the supervision of a S.O.A.R. physical therapist.

**Is your general health:** ☐ Good ☐ Fair ☐ Poor

**Family Health History** (Indicate if your mother, father, brother, sister, aunt, uncle, grandmother or grandfather has had any of the following - & age of onset, if known):

Heart Disease: _____ Hypertension: _____
Stroke: _____ Diabetes: _____
Cancer: _____ Psychological: _____
Arthritis: _____ Osteoporosis: _____
Other: _____

**Past Medical/Surgical History** - Please check if you have ever had:

☐ Allergy to _____
☐ Alzheimer's/Dementia
☐ Anemia/Blood Disorder _____
☐ Anxiety
☐ Arthritis/Osteoarthritis
☐ Asthma
☐ Autoimmune Disease (RA, lupus, sjogren's, psoriatic)
☐ Cancer or Tumor _____
☐ Cardiac Pacemaker
☐ Cardiac/Heart Conditions _____
☐ Chemical Dependency
☐ Circulation/Vascular Problems/PVD
☐ Cognitive/Memory Loss_____
☐ Depression
☐ Diabetes/High Blood Sugar
☐ Dizzyness/Vertigo
☐ Emphyzema/COPD/Bronchitis(chronic)
☐ Fibromyalgia
☐ Fractures/Broken Bones _____
☐ Gallbladder Problems
☐ Hepatitis
☐ Hypertension/High Blood Pressure
☐ High Cholesterol
☐ HIV
☐ Incontinence
☐ Kidney Disease
☐ Metal/Surgical Implants
☐ Multiple Sclerosis
☐ Osteoporosis/Osteopenia
☐ Parkinson's Disease
☐ Pregnant (Possibly/Current Only)
☐ Peripheral Neuropathy
☐ Seizures/Epilepsy
☐ Speech Problems
☐ Stroke
☐ Thyroid Disease
☐ Tuberculosis
☐ Vision Problems_____
☐ **None of Above**

☐ Other Conditions:_____
_____

**Past Surgeries:**

| Type | Date |
|---|---|
| | |
| | |
| | |
| | |
| | |

**Current Prescription Medications, and ANY/ALL Herbs, Supplements, Vitamins, Minerals:**

| Name | Dose (Mg) | Times/Day | HOW (circle one) | REASON |
|---|---|---|---|---|
| | | | Oral Injection Topical Drops Inhale | |
| | | | Oral Injection Topical Drops Inhale | |
| | | | Oral Injection Topical Drops Inhale | |
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Brief Description of Problem: _____
Involved Side: □ Left □ Right □ N/A Dominant Side: □ Left □ Right
Current Diagnosis/Area Injured: _____
Injury Date: _____ Current Surgery Date (if any): _____
Severity of Problem: □ Very Minor □ Minor □ Moderate □ Severe □ Very Severe
What are you doing for this problem now? _____
What are your goals for physical therapy? _____

**Within the past year, have you had any of these symptoms?** (Check all that apply)

□ Chest Pain □ Loss of Appetite □ Heart Palpitations
□ Nausea or Vomiting □ Cough □ Difficulty Swallowing
□ Hoarseness □ Bowel Problems □ Shortness of Breath
□ Weight Loss or Gain □ Dizziness or Blackouts □ Urinary Problems
□ Coordination Problems □ Fever, Chills or Sweats □ Weakness in Arms or Leg
□ Headaches □ Loss of Balance □ Hearing Problems
□ Difficulty Walking □ Vision Problems □ Joint Pain or Swelling
□ Sensory Numbness □ Pain at Night □ Repeated Falls
□ Difficulty Sleeping □ Stabbing pains □ Other_____

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

□ Angiogram □ MRI □ Arthroscopy
□ Myelogram □ Bone Scan □ NCV (nerve conduction velocity)
□ CT Scan □ Stress Test □ EKG
□ X-rays □ EMG □ Other: _____

Signature: _____ Date: _____
Patient (Parent or Guardian if patient is a minor)

Name: _____
Date: _____
DOB: _____

**OPTIMAL INSTRUMENT**
**Difficulty–Baseline**

| **Instructions:** Please circle the level of difficulty you have for each activity today. | **Able to do without any difficulty** | **Able to do with little difficulty** | **Able to do with moderate difficulty** | **Able to do with much difficulty** | **Unable to do** | **Not applicable** |
|---|---|---|---|---|---|---|
| 1. Lying flat | 1 | 2 | 3 | 4 | 5 | 9 |
| 2. Rolling over | 1 | 2 | 3 | 4 | 5 | 9 |
| 3. Moving–lying to sitting | 1 | 2 | 3 | 4 | 5 | 9 |
| 4. Sitting | 1 | 2 | 3 | 4 | 5 | 9 |
| 5. Squatting | 1 | 2 | 3 | 4 | 5 | 9 |
| 6. Bending/stooping | 1 | 2 | 3 | 4 | 5 | 9 |
| 7. Balancing | 1 | 2 | 3 | 4 | 5 | 9 |
| 8. Kneeling | 1 | 2 | 3 | 4 | 5 | 9 |
| 9. Standing | 1 | 2 | 3 | 4 | 5 | 9 |
| 10. Walking–short distance | 1 | 2 | 3 | 4 | 5 | 9 |
| 11. Walking–long distance | 1 | 2 | 3 | 4 | 5 | 9 |
| 12. Walking–outdoors | 1 | 2 | 3 | 4 | 5 | 9 |
| 13. Climbing stairs | 1 | 2 | 3 | 4 | 5 | 9 |
| 14. Hopping | 1 | 2 | 3 | 4 | 5 | 9 |
| 15. Jumping | 1 | 2 | 3 | 4 | 5 | 9 |
| 16. Running | 1 | 2 | 3 | 4 | 5 | 9 |
| 17. Pushing | 1 | 2 | 3 | 4 | 5 | 9 |
| 18. Pulling | 1 | 2 | 3 | 4 | 5 | 9 |
| 19. Reaching | 1 | 2 | 3 | 4 | 5 | 9 |
| 20. Grasping | 1 | 2 | 3 | 4 | 5 | 9 |
| 21. Lifting | 1 | 2 | 3 | 4 | 5 | 9 |
| 22. Carrying | 1 | 2 | 3 | 4 | 5 | 9 |

23. From the above list, choose the 3 activities you would most like to be able to do without any difficulty (for example, if you would most like to be able to *climb stairs*, *kneel*, and *hop* without any difficulty, you would choose: *1. 13 2. 8 3. 14* )

1.____ 2.____ 3.____

24. From the above list of three activities, choose the primary activity you would most like to be able to do without any difficulty (for example, if you would most like to be able to *climb stairs* without any difficulty, you would choose: Primary goal. *13*)

Primary goal. ____

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# PRIVACY NOTICE

**Your Information, Your Rights, Our Responsibilities**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

**Your Rights**
You have the right to:
• Get a copy of your paper or electronic medical record
• Correct your paper or electronic medical record
• Request confidential communication
• Ask us to limit the information we share
• Get a list of those with whom we've shared your information
• Get a copy of this privacy notice
• Choose someone to act for you
• File a complaint if you believe your privacy rights have been violated

**Your Choices**
You have some choices in the way that we use and share information as we:
• Tell family and friends about your condition
• Provide disaster relief
• Market our services

**Our Uses and Disclosures**
We may use and share your information as we:
• Treat you
• Run our organization
• Bill for your services
• Help with public health and safety issues
• Do research
• Comply with the law
• Respond to organ and tissue donation requests
• Work with a medical examiner or funeral director
• Address workers' compensation, law enforcement, and other government requests
• Respond to lawsuits and legal actions

The undersigned has read this notice and has received a copy of this signed notice and the Notice of Privacy Practices, if requested.

Name _____ Signature _____ Date_____

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## Financial Policies, Scheduling Policies and Authorizations – Front & Back

Patient Name: _____
(Last) (First) (M.I.)

**Financial Responsibility & Credit/Debit Card Authorization:** I have requested professional services from Shore Orthopedic & Athletic Rehabilitation, P.A., T/A S.O.A.R. Physical Therapy ("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 said services. I understand that all copayments, coinsurances, and deductibles for said services are due and payable on the date services are rendered and agree to pay all such charges incurred at each visit, **unless an alternate payment plan** has been made in advance. 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.

If an explanation of benefits (EOB) from my insurance carrier demonstrates that an amount is due to this provider, I will pay them the amount due within 30 days of being invoiced. With the credit or debit card copy I have provided, I authorize the provider to charge my card for balances that I fail to pay within that 30 day period. If the insurance carrier fails to assign benefits to this provider and instead makes payment to the insured, and the checks are not signed over to the provider, this credit/debit card authorization extends to the amounts paid to the insured.

**Payment Plans & Credit/Debit Card Authorization:** Only a payment plan agreement can modify the amount of payments I must pay the provider and when they are due in the above section. If I have a payment plan agreement and I do not make my payments as they are due on each day of service, I authorize the provider to charge the credit/debit card I have provided for all outstanding payment plan balances.

**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 updating it.

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 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 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 make out the check to me and mail it directly to Provider.

**Authorization to Release Information:** I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

**Authorization to Provide Care & Use Personal Health Information:** This patient (or their authorized signing representative) authorizes Provider to provide physical therapy care as it relates to their diagnosis and the patient's prescription, if provided by a referring physician. I also authorize Provider to use my personal health information as necessary for their health care operations. I understand that I can revoke my authorization and/or restrict use of certain personal health information if I inform this office in writing.

**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.

# No-Show / Cancellation Policy

*Please Read Carefully*

We realize that emergencies and other scheduling conflicts arise and are sometimes unavoidable, however, advance notification allows us to fulfill other patient's scheduling needs and keeps the clinic operating at its most efficient level. Due to our one-on-one 60-minute treatments, missed appointments are a significant inconvenience to your treatment, the clinic and other patients.

**1.** Please provide our office with 24-hour notice to change or cancel an appointment. Patients who do not attend a scheduled appointment or do not provide 24-hour notice to change a scheduled appointment may be responsible for a $50.00 office visit charge. This charge cannot be billed to insurance and must be paid on or before the next scheduled appointment.

**2.** We reserve your appointment time just for you. We do not double-book our patients so that we may provide optimum treatment outcomes for all our patients. 24-hour notice allows us to place another patient in your cancelled appointment time, to receive needed treatment.

**3.** Certain accident claims adjusters expect regular attendance to therapy as a requirement of an approved treatment plan. If appointments are missed or cancelled on a regular basis it could affect the status of your claim. Your treatment plan has been established by your medical practitioners to get you back to your regular activities as quickly as possible. Missing appointments hinders that process and may end up prolonging recovery.

**4.** Your clinician will develop a specific plan of care based on your individual goals/outcomes and physical impairments. Adhering to this plan of care (frequency/duration) is crucial to your outcome.

**5.** At our discretion, you may be placed on a same day scheduling policy for your treatments, which would not allow you to schedule any appointments in advance.

_____**initial here to acknowledge that you've read and fully understand this policy**

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

Signature: _____ Date: _____
Patient/Insured (Parent or Guardian if patient is a minor)

Signature: _____ Date: _____
Person accepting responsibility for fees & providing a copy of their credit/debit card

Witness: _____ Date: _____