Mt. Freedom Physical Therapy

10 West Hanover Ave, Randolph, NJ
Phone: 973-895-4300
Fax: 973-895-4302
www.mtfreedomphysicaltherapy.com

Verification Form

Patient Name_____ DOB___/____/_____

Patient Address_____

City_____State_____Zipcode_____

Home Phone (_____)_____Cell (_____)_____

Emergency Contact Name_____Phone (_____)_____

Relationship to Patient: ___Parent ___Spouse __Sibling __Other_____

If patient is a minor, name of financially responsible adult_____

Address_____

City_____State_____Zipcode_____

Home Phone (_____)_____ Cell (_____)_____

Patient Acknowledgment_____ **Date:** _____

Financial Responsibility Form

It is your responsibility to be aware of charges in your insurance benefits. The following benefits were communicated from your insurance company. This information may not be accurate. Therefore, you will be responsible for any remaining balance. Initials: _____

Primary Insurance Company_____ Policy Current Date___/____/____

Primary Insurance Holder Name_____

Address_____DOB_____/_____/_____

Primary Insurance Company Billing Address_____

Secondary Insurance Company_____Policy Current Date___/___/____

Secondary Insurance Company Billing Address_____
Type of Plan: __HMO __PPO __POS ___Auto __ Workers Comp __ Medicare __ Medicare HMO ___ Other

I, _____, authorize Mt.Freedom Physical Therapy to treat me and to release to my insurance company/lawyer/employer any information concerning health care, advice or treatment provided to me. This information will be used for the purpose of evaluating claims for benefits.

Patient Acknowledgment_____**Date:** _____

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Physical Therapy

10 West Hanover Ave. Randolph, NJ 07869

Phone: (973) 895- 4300 Fax: (973) 895-4302 Website: mtfreedomphysicaltherapy.com

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MEDICAL HISTORY FORM

Patient Name _____

Family Physician/Internist _____

Date of Injury _____

Why are you here? _____

Please review the list below. Circle yes (Y) or no (N) whether or not these pertain to you as pastor present conditions.

Cardiac Surgery	(Y)	(N)
MI (heart attack)	(Y)	(N)
Hypertension (high blood pressure)	(Y)	(N)
Hypotension (low blood pressure)	(Y)	(N)
Pacemaker	(Y)	(N)
Emphysema/Asthma	(Y)	(N)
Bleeding/Bruising (recent history)	(Y)	(N)
Diabetes	(Y)	(N)
Hypoglycemia	(Y)	(N)
Cancer/Tumors/Growths	(Y)	(N)
Active Seizure Disorder	(Y)	(N)
Osteoporosis	(Y)	(N)
Swelling of Extremities	(Y)	(N)
Fractures	(Y)	(N)
DATE: _____ AREA _____		
DATE: _____ AREA _____		
Artificial Joints	(Y)	(N)
Light-Headedness/Dizziness	(Y)	(N)
Anxiety/Panic Attacks (recent)	(Y)	(N)
Depression (recent)	(Y)	(N)
Alzheimer's	(Y)	(N)
Shortness of Breath	(Y)	(N)
Chest Pain/Angina/Hear Attack	(Y)	(N)
Urinary Urgency/Incontinence	(Y)	(N)

Are you pregnant?	(Y)	(N)
Stroke	(Y)	(N)
Brain Injury	(Y)	(N)
Multiple Sclerosis	(Y)	(N)
Spinal Cord Injury	(Y)	(N)
History of Pressure Sores	(Y)	(N)

Other:

_____

_____

Are you in pain? (Y) (N)

Location of pain: _____

If you answered yes to any of the above, are you under care of an MD for these conditions? (Y) (N)

Allergies: _____

_____

Surgeries within the last 3 years (list any and all that apply and include dates: _____

_____

_____

_____

What are your treatment goals? _____

_____

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Patient Name _____Date ____/____ /_____
(Relationship to Patient : _____ Self _____ Guardian _____Other)

I authorize Mt. Freedom Physical Therapy to release to appropriate agencies, any information acquired in the course of my (or the above named patient's) examination and treatment necessary to secure payment for services provided.

Signature _____ Date ____/_____ /_____

I acknowledge that the **Notice of Privacy Practices** was given to me at Mt. Freedom Physical Therapy and that I have read and understood the notice.

Signature _____Date ____/____ /_____

Student Observation**:** From time to time, physical therapy and pre-physical therapy students may be present observing. Students do not view medical charts or personal information. I understand, give my consent, and acknowledge my approval.

Signature _____ Date ____/____ /_____

In response to recent events, we have been prompted to enact a new office policy regarding frequent/last minute appointment cancellations. To be determined at our discretion, frequent cancellations within 24 hours of your appointment will be charged a $25 cancellation fee. Payment will be collected on the next visit date.

Signature _____ Date ____/____ /_____

Mt. Freedom
Physical Therapy
10 W. Hanover Ave. Suite 115
Stephen Aiello MsP.T.
P 973 895 4300 F 973 895 4302

My insurance coverage and limitations including, but not limited to co-pay, coinsurance, and deductibles was explained to me in detail. I understand that I will be responsible for any charges that are accepted by my insurance, but not paid by them for any reason.

I also understand that charges will be collected at the office upon the receipt of the Explanation of Benefits from my insurance company.

Print:_____

Sign:_____

Date:_____

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Please provide a detailed list of your medication, dosage, and frequency:

Patient name: _____

Medication	**Dosage**	**Frequency**

Patient Signature: _____

Date: _____

Protecting Your Medical Identity

Most people are aware of the risk of identity theft to financial records, social security number, etc. As a recipient of healthcare services, you also need to be aware of the risk of other people using your identity to obtain medical services under your insurance coverage. Medical Identity Theft is a real risk in our society and the consequences can be very serious. For example, if a person uses your identity to obtain services, your medical record may be compromised by the other person receiving treatment for illnesses that would be contradictory to your health history.

Due to these risks, we take precautions to help protect your medical identity. This includes requiring our admissions staff to require that you show photo identification at the point of admission or at the point of your first visit. Please be understanding of our staff when they ask you for ID, as it is a part of the process to help protect your Medical Identity. You should also be proactive in guarding and protecting your insurance card number, Medicare number, and Social Security number.

You should be aware and watch for the following Red Flags as possible signs of Medical Identity Theft. If you become aware of any of these areas of concern, please let us know so we can assist you in making any necessary corrections and notifications of appropriate government agencies. If you prefer, we also encourage you to contact the Federal Trade Commission at 877-FTC-HELP to report any issues.

- **You receive a bill or a notice of insurance benefits (Explanation of Benefits EOB) for services you did not receive.**
- **You receive a collection notice from a bill collector for a bill that you think does not relate to services you received.**
- **Your insurance company notifies you that coverage for legitimate hospital stays is denied because insurance benefits have been depleted or a lifetime cap has been reached.**
- **You notice information added to your credit report by a healthcare provider or insurer.**
- **You receive an inquiry for an insurance fraud investigator or a law enforcement agency.**