OAKLAND PHYSICAL THERAPY, PA
Orthopedic and Sports Rehabilitation

Dr. Robert Freund, DPT
43 Yawpo Ave, Suite 10 Oakland, NJ 07436

Patient Registration Form

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ SSN: _____

Gender: M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Widowed ☐ Separated ☐

Street Address: _____ City: _____

State: _____ Zipcode: _____ Home Phone: _____

Cell Phone: _____ E-mail Address: _____

Employer: _____ Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Insurance Information

Primary Insurance: _____ ID#: _____

Subscriber's Name: _____ DOB: _____ Relationship: _____

Address: _____ Phone: _____

Provider Services Phone: _____ Billing Address: _____

Worker's Compensation Only

Case Manager's Name: _____ Phone: _____

Employer's Name & Address: _____

Employer's Phone: _____ Claim #: _____

Date of Injury: _____ W/C Insurance Company: _____

For Motor Vehicle & Other Law Suits Only

Lawyer's Name & Address: _____

Lawyer's Phone: _____ Date of Incident: _____ Claim #: _____

Physician Information:

Referring Physician: _____ Phone: _____

Address: _____ Fax: _____

Primary Care Physician (if different from above): _____

Date of last physical exam: _____ How did you hear about OPT? _____

Current Complaint:

Briefly describe the reason for your visit: _____

_____

Date Symptoms Began: _____ How did your problem start? _____

_____

Have you had surgery for this condition? Y ☐ N ☐ Date of Surgery (if applicable): _____

What makes problem: Worse? _____ Better? _____

Have you had any diagnostic testing? X-Ray ☐ MRI ☐ CT Scan ☐ EMG ☐ Other ☐

What were the results? _____

What is your AVERAGE or TYPICAL symptom level?

None ←---- 0 ---- 1 ---- 2 ---- 3 ---- 4 ---- 5 ---- 6 ---- 7 ---- 8 ---- 9 ----10 ----→ Worst imaginable

Have you ever had this symptom or injury before? Y ☐ N ☐

If yes, explain treatment and outcome: _____

Please list any PRESCRIPTION medications you are taking: _____

_____

Have you taken any OVER-THE-COUNTER medication in the past 2 weeks? (Please check Y or N)

Y ☐ N ☐ Anti-inflammatory (Advil, Aleve)	Y ☐ N ☐ Decongestant (Mucinex, Sudafed)	Y ☐ N ☐ Vitamins/Minerals/ Supplements
Y ☐ N ☐ Pain Reliever (Tylenol)	Y ☐ N ☐ Antihistamine (Zyrtec, Claritin)	Y ☐ N ☐ Other: _____

Do you: **Smoke?** Y ☐ N ☐ **Drink Alcohol?** Y ☐ N ☐ How often? _____ **Use other drugs?** Y ☐ N ☐

Please list any previous surgeries, or other conditions for which you have been hospitalized:

Date (Approx) Surgery/Reason for hospitalization

_____ _____

_____ _____

_____ _____

Have you had physical therapy previously? Y ☐ N ☐

Date (Approx) Injury

_____ _____

_____ _____

_____ _____

Have you ever had any of the following? *(Please check Y or N)*

Y ☐ N ☐ Angina/ Chest Pain	Y ☐ N ☐ Osteoporosis	Y ☐ N ☐ Epilepsy
Y ☐ N ☐ Kidney Disease	Y ☐ N ☐ Anemia	Y ☐ N ☐ Stroke
Y ☐ N ☐ High Blood Pressure	Y ☐ N ☐ Depression	Y ☐ N ☐ Asthma
Y ☐ N ☐ Tuberculosis	Y ☐ N ☐ Hepatitis	Y ☐ N ☐ Multiple Sclerosis
Y ☐ N ☐ Diabetes	Y ☐ N ☐ Thyroid Problems	Y ☐ N ☐ Pacemaker
Y ☐ N ☐ Emphysema	Y ☐ N ☐ HIV/ AIDS	Y ☐ N ☐ Rheumatoid Arthritis
Y ☐ N ☐ Other Arthritic Conditions	Y ☐ N ☐ Circulation Problems	

If you checked yes for any of the above conditions, please explain: _____

_____

Y ☐ N ☐ Heart Disease/ Heart Attack: If yes, describe_____

Y ☐ N ☐ Cancer: If yes, what type? _____

Y ☐ N ☐ Chemical Dependency (e.g. Alcoholism): If yes, describe _____

Y ☐ N ☐ Allergies: If yes, list _____

In the past three months, have you experiences any of the following? *(Please check Y or N)*

Y ☐ N ☐ Fever/ Chills/ Sweats: If yes, describe _____

Y ☐ N ☐ Unexplained weight change: If yes, describe _____

Y ☐ N ☐ Fatigue: If yes, describe _____

Y ☐ N ☐ Nausea/ Vomiting: If yes, describe _____

Y ☐ N ☐ Changes in bowel/ bladder function (difficulty, frequency, etc) If yes, describe _____

_____

Y ☐ N ☐ Dizziness/ Lightheadedness: If yes, describe _____

Y ☐ N ☐ Numbness/ Tingling: If yes, describe _____

Y ☐ N ☐ Shortness of breath: If yes, describe _____

What is your current Height: _____ Weight_____

For Women: *(Please check Y or N)*

Have you ever been pregnant? Y ☐ N ☐ Number of pregnancies _____

Are you currently pregnant? Y ☐ N ☐ Are you taking fertility drugs? If yes, list _____

Please sign and date below authorizing that the information provided above is correct to the best of your knowledge.

Signature: _____ Name: _____

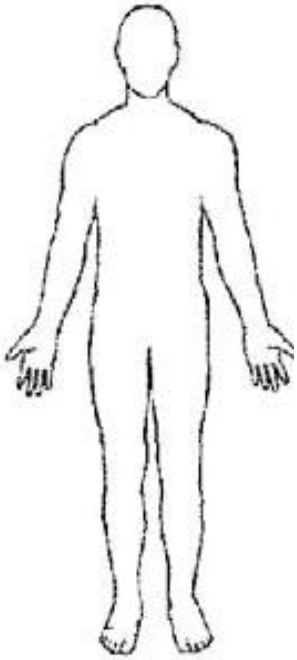
Date: _____

Current Symptoms-

Assessment Chart

Instructions:

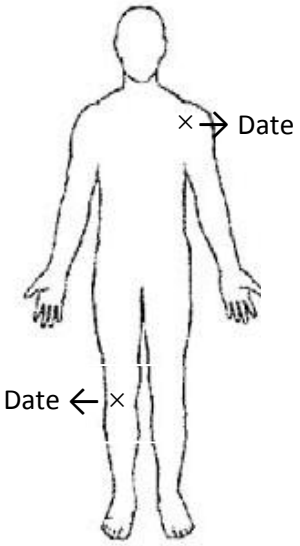
1. Place an "X" on each area of the body diagram where you are feeling symptoms.
2. Write the date each area of symptoms started for this episode, to the best of your memory.



Front

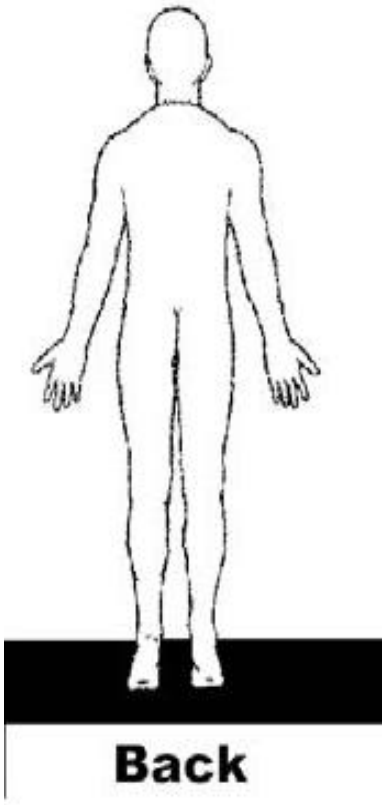
This list provides some examples of words that may help describe your symptoms. Check all that apply.

___ Sharp ___ Shooting
___ Burning ___ Dull
___ Ache ___ Tingling
___ Heavy ___ Tight
___ Throbbing ___ Numb
___ Pulling ___ Stabbing



This list provides words that may help describe the behavior of your symptoms. Check all that apply.

___ Constant (never goes away)
___ Intermittent (relieved in some positions or at rest)
___ Variable (sometimes worse than other times)
___ Unchanging (always the same)
___ No symptoms



Back

How are your symptoms progressing recently?

___ Improving
___ Worsening
___ Staying the Same

Patient Name: _____ Date: _____

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Policy Agreement

Payment Policies:

- Patients are responsible for any co-payments, deductibles and co-insurances from their insurance company.
- **Payment is expected at the time services are rendered, unless other agreements have been made in advance**. Payment by check should be made out to Oakland Physical Therapy.
- I authorize Oakland Physical Therapy to release my insurance carrier, upon their legal request, any information acquired during the course of my examination and treatment and permit payment be made directly to Oakland Physical Therapy.
- **Medicare Patients:** I understand that Medicare may deny payment for certain services, such as services they determine are not medically necessary, I agree to be personally and fully responsible for such charges. If I **do not** have secondary medical insurance I will be fully responsible for costs that Medicare does not cover. If I **do** have secondary insurance coverage and my secondary plan has a co-payment, I will be fully responsible for this amount.
- **All Non-Medicare Patients**: I understand that it is my responsibility to know my insurance policy and to bring the most recent insurance card to each visit. If my plan requires a referral and I fail to bring one, I understand that I will not be seen by the therapist unless I pay cash for the visit. If I choose to pay cash, I will be provided the appropriate documentation from the office to submit the claim on my own behalf. If there is a discrepancy in the amount reimbursed by my insurance carrier, I agree to pay the rate set by Oakland Physical Therapy. This agreement, therefore supersedes any purported terms claimed by any managed care or other insurance company.
- **Cancellation Policy:** Appointments should be scheduled, changed or canceled at least 24 hours in advance. There will be a $25.00 fee charged if I miss an appointment without giving 24 hour notice.
- **Red Flag Identity Theft Rule**: We are now required by law to ask for a photo ID at the time of each visit. Please have your photo ID with you at all times.

I hereby authorize use of this signature on all submission of insurance claims.

_____ _____

Signature of Patient or Legally Responsible Person Name (Please Print)

_____ _____

Relationship/Reason why patient is unable to sign Date

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Privacy Practice Notice

Patient Name: _____ Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment and health care operations.
- A description of each of the other purposes from which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke my authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The rights to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information.
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ **Date:** _____

Relationship to patient (if signed by a personal representative of patient): _____

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To All Physical Therapy Patients:

Below are a few notes that we ask you to review regarding physical therapy prescriptions and our policy on electrodes that may be used for electric stimulation during your physical therapy treatment.

This facility uses disposable electrodes when using electric stimulation as a modality on our patients. We use disposable electrodes that are used solely on each patient and after discharge, the electrodes are discarded. Due to the concern regarding AIDS and other infectious disease, this clinic follows a strict protocol using disposable electrodes. We feel that by using disposable electrodes we are offering the safest treatment possible and decreasing the possibility of spreading infectious diseases to our patients.

Therefore, there is a **one-time $10.00 charge** for these electrodes. We will collect this fee on the date of service in which electric stimulation is initially provided to you.

All prescriptions for physical therapy are written for a specific time frame, i.e., "3 times a week for 4 weeks". This means that you have 12 available sessions for physical therapy that must be completed within four weeks of starting the therapy. Medicare requires that therapy be completed within 30 days of the date the prescription is written.

In order to continue physical therapy after the time period has expired you must get a new prescription. You can obtain a new prescription by calling your physician and asking them to fax a new prescription to our facility or by returning to the physician for an office visit.

It is your responsibility to see that you have a current prescription at all times while undergoing physical therapy. We are more than happy to provide you with a copy of your prescription for your records, and we will do our best to remind you when it is getting close to expiring. When you get toward the end of your initial number of visits, please contact your physician to renew the prescription; there should never be a time in which you do not have a current prescription on file. **You will be held responsible for all costs incurred on an expired prescription that your insurance does not cover.**

Also, please advise our staff of your upcoming doctor's visits so we can have Dr. Freund forward a progress note.

If you have any questions regarding the above information, please feel free to ask our staff at any time.

Sincerely,
Oakland Physical Therapy

Dr. Robert Freund, DPT