OF SOUTH JERSEY
Advanced
PHYSICAL THERAPY
Specializing in Sports Medicine & Geriatrics

856-728-4100
www.advancedphysicaltherapyofsouthjersey.com · rob.romalino@advancedphysicaltherapyofsouthjersey.com

Patient Name: Last_____ First_____

Address_____

City_____ State_____ Zip _____

Phone# (C)_____ (H)_____ (W)_____

Date of Birth_____

Social Security# (**REQUIRED FOR BILLING**)_____

If Patient is a Minor, a Parent's Name & Social Security# are Required_____

Emergency Contact Name_____Phone_____

Patient's Employer_____

Phone#_____

Employer Address_____

City_____ State_____ Zip Code_____

Release: I hereby authorize the release of any information that might be requested by my physician and/or insurance company.

Patient responsibility & Assignment: I also assign & request payment of medical benefits to the above stated provider for physical and occupational therapy services. I acknowledge that I am responsible for providing ALL insurance coverage & immediately notifying us of any changes in such medical coverage. Failing to provide active insurance cards for both primary and secondary insurances will result in my financial responsibility for any outstanding balances. I am also responsible for forwarding any payment from my insurance company to the rendering medical practitioner at the time of receipt. I also understand that I am financially responsible for the payment of my bill and I am responsible for any additional fees that are incurred for administrative expenses, collection agencies or small claims court due to the lack of payment by me as well as an additional $100 charge per day for any appearance required of us in small claims court.

Finally, if you received treatment for injuries sustained during a slip and fall or motor vehicle accident and are currently represented by an attorney, you are still responsible for any co-payments, co-insurances and/or deductibles on your account. Regardless of what your attorney states, we require payment for services provided prior to any lawsuits being settled. We will gladly provide you with a receipt of any payments your attorney can provide you reimbursement.

X_____ **_____**

Guarantor/Parent/Guardian Signature **Date**

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Patient Name_____ **Date**_____

Date of your next physician's visit_____

1. Date of Onset/Injury_____
2. Have you ever had these symptoms before?_____
3. Pain Level (0-10) Now:_____ Worst Past 24 Hrs:_____ Best Level Past 48 Hrs:_____
4. Check which apply to your current condition:

_____Work Related	_____Recurrence of Previous Injury
_____Injury Related to a Fall	_____Motor Vehicle Accident
_____Injury Related to Lifting	_____Cause Unknown
_____Athletic/Recreational Injury	_____Other:_____

Have you had a related Surgery?	Yes	No	If female, are you Pregnant?	Yes	No
Do you have any Metal Implants?	Yes	No	Do you have a Pacemaker?	Yes	No
Do you have a History of Seizures?	Yes	No	Do you have any Allergies?	Yes	No

Do you have, or have you had any of the following:

	Yes	No		Yes	No
Diabetes	___	___	Hypoglycemia	___	___
Chest pain/Angina	___	___	Arthritis	___	___
High Blood Pressure	___	___	Osteoporosis	___	___
Hernia	___	___	Cancer	___	___
Heart Attack	___	___	Dizziness/Fainting	___	___
Fractures	___	___	Stroke	___	___
Surgeries	___	___	Rheumatic Arthritis	___	___
Asthma/Breathing Problems	___	___	Other Problems	___	___

If you are presently taking any Medication, please list on the following page

Signature_____

Relationship to Patient (spouse, guardian, parent etc…)_____

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Medications/Herbals/Supplements/OTC: Drug Name & For What Condition	Frequency of Use	Oral, Injection, Drops, IV (Circle One)
1.		**Oral, Injection, Drops, IV**
2.		**Oral, Injection, Drops, IV**
3.		**Oral, Injection, Drops, IV**
4.		**Oral, Injection, Drops, IV**
5.		**Oral, Injection, Drops, IV**
6.		**Oral, Injection, Drops, IV**
7.		**Oral, Injection, Drops, IV**
8.		**Oral, Injection, Drops, IV**
9.		**Oral, Injection, Drops, IV**
10.		**Oral, Injection, Drops, IV**
11.		**Oral, Injection, Drops, IV**
12.		**Oral, Injection, Drops, IV**
13.		**Oral, Injection, Drops, IV**
14.		**Oral, Injection, Drops, IV**
15.		**Oral, Injection, Drops, IV**

_____ (Patient Signature) **_____(Date)**

_____(Therapist Reviewed The Medication List – Signature Required)

STOP!!!
Administration Use Only:

_____ ***G8427: Therapist attests to reviewing medications*** _____ ***G8430: Patient NOT eligible***

_____ ***G8428: Medications NOT documented***

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Consent To Treatment & Release Of Information

I understand that I have been referred for rehabilitative treatment and care to Robert J. Romalino, P.T., P.C. doing business as Advanced Physical Therapy of South Jersey. Advanced Physical Therapy of South Jersey will provide a comprehensive evaluation and prescribe an individual treatment plan based on their evaluation. I understand that I have the right to ask and have any questions answered prior to receiving any treatment including any risks or alternatives to the treatment plan that will be prescribed for me by my therapist. By signing this agreement, I consent to have Advanced Physical Therapy of South Jersey provide treatment and care as prescribed by my physician and/or recommended by my therapist. I authorize the release of medical information to my physician(s) and/or to my insurance carrier in order to process any claims.

Notice Of Attendance Requirements

I understand that **24-hour advance notification** is required in order to change or cancel an appointment. If I do not attend my scheduled appointment and do not have a valid doctor's excuse to miss such an appointment, I also understand that my doctor and/or insurance company may be notified. Furthermore, any patient that habitually misses appointments without phoning may be subject to a **$25.00 charge** and your rehabilitation may be adversely effected. Finally, I understand that I may be discharged from therapy due to lack of compliance. If you arrive late to **ANY** scheduled appointment, the therapist reserves the right to re-schedule your session…Please be prompt for all scheduled appointments!!

Signature_____ **Date**_____

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Health Insurance Disclaimer ***Office Copy***

Advanced Physical Therapy has no more reliable way of verifying your insurance eligibility other than to contact the customer service or member service number located on your insurance card. Often times the information provided to us by a representative of your insurance company is incorrect. For this reason, we will verify your eligibility to attend physical/occupational therapy at Advanced Physical Therapy however we will no longer provide Co-Pay or Deductible information. If you are unsure if you have a Co-Pay or Deductible, we **STRONGLY** encourage you to contact your insurance company and become familiar with your insurance benefits.

Co-Payments may be made each time you arrive at therapy or we will mail you an invoice. The Sewell offices do not accept cash payments!! Typically we invoice Co-Pays / Deductibles the 1st week of each month. Often times we will delay invoicing until your first physical/occupational therapy date of service has been paid by your insurance company. We delay invoicing to ensure we invoice you correctly the first time. As always, you are welcome to be proactive in making payments on your account to avoid large balances even if you have not received an invoice for our services. All payments received will be applied to your account and any account credit that you have after the final insurance payment has been applied will be promptly refunded.

Acceptable forms of payment are Cash (except in Sewell), Check, Visa, MasterCard, AMEX and Money Order. As a courtesy to our patients, we allow patients to set up payment plans free of administrative charges provided you make a **minimum monthly payment of $50.00** however, this must be approved by Christy the Office Manager. **If you make less than a $50.00 monthly payment, we will charge your account a monthly $25.00 administrative processing fee without regard to the account balance due**. If we invoice you three times to the address provided when you scheduled your first appointment and we receive no response, your account will be forwarded to our collection service. The cost of this service, to you the patient, will be $50.00 and this charge will be added to your account balance. If you do not contact us to make payment arrangements upon receipt of this notice, our collection service will next file a claim with small claims court. The cost of this service to be added to your account is $22.00 for the court filing fee and a $100.00 court appearance fee. We have been very successful in small claims court no matter the size of the balance and wage garnishments are common. Please just call the office to make payment arrangements if you are having financial difficulty!!!

Finally, if you received treatment for injuries sustained during a slip and fall or motor vehicle accident and currently represented by an attorney, you are still responsible for any co-payments, co-insurances and/or deductibles on your account. Regardless of what your attorney states, we require payment for services provided prior to any lawsuits being settled. We will gladly provide you with a receipt of any payments you have made on your account so you can turn them in to your attorney for reimbursement.

Signature_____ **Date**_____

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