PROFESSIONAL ORTOPEDIC ASSOCIATES
PHYSICAL THERAPY

NOTICE OF PRIVACY

Attached please find POA'S Notice of Privacy Practices. Your name and signature on this cover sheet indicate that you have received a copy a POA'S Notice of Privacy Practices on the date and time indicated. If you have any questions regarding this information set forth in the POA'S Notice of Privacy Practices, please do not hesitate to contact the Privacy Officer at:

732-530-4949

Or

Fax Inquiries to: (732) 530-3234

NAME (Please print)______________________________

SIGNATURE______________________________

Date and Time Notice Received ______________________________

Site Location ______________________________

PROFESSIONAL ORTHOPEDIC ASSOCIATES PHYSICAL THERAPY

Patient Medical History

The important information that you provide by filling out this form, will help us perform a thorough evaluation of your condition. If you do not understand any questions, please leave it blank and your therapist will assist you. Thank you.

Name:	Last date worked due to injury:
Family Physician:	Referring Physician:

	YES	NO
Is an attorney involved in this case?		
Have you had surgery for this injury?		
Type of surgery		

Have you had the following services for this episode/injury?

	Yes	No		Yes	No
General Practitioner			X-Rays		
Orthopedist			CT-Scan		
Neurologist			MRI		
Podiatrist			EMG-NCV		
Physical Therapy			Myelogram		
Occupational Therapy			Other		
Chiropractor					
Other					

Do you have or have you ever had any of the following?

	Yes	No		Yes	No
Cancer			Easy bruising/excessive bleeding		
Asthma, Bronchitis, or Emphysema			Weight loss/gain		
Shortness of Breath/Chest pain/Cough			Numbness/Tingling		
Heart Disease			Severe or frequent headaches		
Heart racing in your chest			Weakness		
High blood pressure			Fatigue/Malaise		
Pacemaker/Defibrillator			Fever/Chills/sweats		
Stroke			Sleeping problems		
Blood clots			Vision problems		
Circulation problems			Hearing difficulty		
Anemia			Sexual difficulties		
Dizziness/Fainting			Joint replacement		
Diabetes			Neck injury/surgery		
Thyroid problems			Shoulder injury/surgery		
Infectious disease			Elbow injury/surgery		
Arthritis			Back injury/surgery		
Gout			Knee injury/surgery		
Osteoporosis			Leg, ankle, foot injury/surgery		
Epilepsy/Seizures			Arm/Leg swelling		
Emotional/Psychological problems			Stress at home or work		
Heart burn/indigestion			Are you pregnant?		
Constipation/Diarrhea					
Blood in stools					
Difficulty urinating					
Urinary incontinence					
Hernia					

Do you have a family history of:

	Yes	No		Yes	No
Diabetes			Cancer		
Heart Disease			Alcohol or Drug dependency		
High Blood Pressure			Arthritis		
Stroke			Depression		

Tobacco use: How many cigarettes/packs do you smoke in a day? ________, for how many years? ________
How many days a week do you drink alcohol? __________

Allergies: List any medication(s) you are allergic to: ______________________________

Are you Latex sensitive? Yes No List any other allergies: ______________________________

Do you have an Advanced Clinical Directive of Do Not Resuscitate? Yes No

Please list all prescription and over the counter medications that you are currently taking.

Name of medication	Reason taken	Dosage	Frequency	Route (oral, injection, inhaler, etc.)	Date stopped

Based on the awareness of your diagnosis, what are your expectations/goals while in this program?

____

______________________________ Date ______________________________ Date
Therapist signature Patient signature

ASSIGNMENT OF BENEFITS/APPOINTMENT OF ATTORNEYS

I hereby assign all rights and benefits due me from my insurance carrier to Professional Orthopaedic Associates ("POA") and authorize and empower POA to appeal a determination by a carrier to deny, reduce or terminate my benefits including, but not limited to, the filing of a lawsuit or fee arbitration. Furthermore, I authorize and direct my insurance carrier to pay the proceeds of any benefits due me directly to POA. A copy of this can be considered as an original for insurance purposes. ____ *(initials)*

I acknowledge and understand that I am responsible for all of the charges for all of the services rendered to me or any member of my family. Although I have requested the doctor to bill my insurance company on my behalf, I clearly understand that it is still my responsibility to make sure the bill is paid within a reasonable amount of time. If for any reason any portion of the bill is not paid by my insurance carrier, I further agree to make arrangements for prompt payment of the bill. ____ *(initials)*

I agree that should I receive direct payment from my insurance carrier for services rendered to me, I will promptly sign over the check to the physician's office. I understand that should I not turn over the proceeds, an action for collection may be filed against me in which I agree to be responsible for payment of any court costs and attorney fees involved in efforts to collect the entire fee billed by the doctor, not just what has been paid to me by my insurance carrier. ____ *(initials)*

I agree that if POA treats me for any problem that is involved in litigation or involves a claim for personal injuries, I will immediately notify the Billing Department for my POA provider. At the time any settlement funds are disbursed or received, I promise to pay any and all of my provider's and POA's bills. ____ *(initials)*

I understand that my provider and POA may each bill for services rendered independently. I authorize this office to submit their bills to any insurance company with which I (or my spouse) have an insurance policy or any company against which I may proceed for medical expense benefits. ____ *(initials)*

In the event that the doctor elects to bring a lawsuit or petition for arbitration against the insurance carrier, I assign my rights, title and interest under any section of any insurance policy under which I am entitled to proceed for benefits. This assignment shall allow an attorney of their choosing to bring suit or submit to arbitration their claim for any unpaid bills for treatment rendered. My provider and POA may designate such attorney beginning thirty-one (31) days after any bill for services rendered becomes due. I agree to fully cooperate with them in the collection of any benefits from the insurance carrier including full cooperation with the chosen attorney. ____ *(initials)*

In the event this assignment is held invalid for any reason, I hereby authorize POA to appoint an attorney of its choice to represent me directly against an insurer from which I may collect any & all benefits and to bring a claim in a forum of the attorney's choice. This appointment is intended to enable the attorney to collect the bills of POA and this appointment does not authorize the selected attorney to represent me in any third-party action. Further, this appointment will not conflict with any other attorney who currently represents me. ____ *(initials)*

By consenting to having a law firm of POA's choosing represent me, I understand that in such lawsuits my confidentiality may not be protected and personal information may be revealed. I authorize my provider and POA to release any and all information concerning my injury or illness and its treatment to the attorney designated by the assignee or third person that are involved in the action to collect benefits. ____ *(initials)*

I have read, understand and agree to the above. ____ *(initials)*

_______________________________________ _______________________

Patient Name – please print Date

____

Patient's Signature or Signature of Parent/Legal Guardian

Authorization to Use or Disclose Health Information
Professional Orthopaedic Associates, P.A.

Date of Request____________

Patient Name ____ Date of Birth ____________

Address ____

**As required by the Privacy Regulations, Professional Orthopaedic Associates, P.A. may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization. **

I, ______________________, give permission for Professional Orthopaedic Associates, P.A. and any of its employees to release any or all of my Patient Health Information to the following relatives, friends or acquaintances.

____

Patient information to be disclosed: All

For the specific purpose of: Any

Effective date for authorization: ______________________

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, this information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office that revocation will not effect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

____ ____________________

Signature of Patient of Patient's authorized representative Date

____ ____________________

Authorized signature of Professional Orthopaedic Associates staff Date

Legal Assignment of Benefits & Designation of Authorized Representative

I, _________________________, represent that I have valid and in-force insurance and/or employee health care benefits coverage, and hereby assign and convey directly to Dr. (the "provider(s)"), as my Statutory Derivative Beneficiary (SDB), commonly known as an Designated Authorized Representative, and a Claimant under the "Patient Protection and Affordable Care Act" (PPACA), existing ERISA and other applicable federal and state laws, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from the provider(s), regardless of the provider's managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to the provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from the provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the provider(s), to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, chose in action, or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s) under any applicable insurance policies, employee benefits plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I received from the provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by the provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, to bring suit by the provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

______________________________________ ___________________________

Signature of Insured / Guardian Date

____

Print Name of Insured/Guardian

Patients with no insurance: Payment is expected at the time of service. A specific payment plan acceptable to both you and the office may be arranged.

Patients with insurance: Deductibles and all co-insurances are expected at the time of service. Your co-insurance is not covered by your insurance and is not always an exact percentage. You will be sent a statement showing both your account balance and your anticipated responsibility. If a patient's balance remains unpaid for more than 90 days, the patient's account may be turned over to an attorney/collection agency for collections. If your account is sent to collections, you will be responsible for all collection fees generated.

INSURANCE POLICY

We extend to our patients the courtesy of allowing you to assign your insurance benefits directly to our office. This policy may reduce your out-of-pocket expense.

Please note the following:

1. **The privilege of insurance assignment begins when your insurance is qualified and the insurance forms received. Until that time you must pay for all services rendered.**
2. **All deductibles must be made prior to submitting your insurance claims.**
3. **Since we do not own your insurance policy, we are limited in our efforts to collect from your insurance company. We expect that you act on your own behalf with your insurance carrier. Frequent calls on the status of your claim often help speed up this process.**
4. **Due to the recent changes in our status with most insurance companies, it will be your responsibility to turn over to our office any checks and related explanations of benefits that your insurance company issues to you for services rendered with Professional Orthopaedic Associates in a timely manner.**
5. **It is our goal of this office to provide you with the finest quality of care available. If you have any questions regarding your healthcare or any of our office policies, please do not hesitate to let us know.**
6. **If it becomes necessary to utilize a collection agency due to nonpayment of bill, you will be responsible for all fees charged by that agency as well as your balance.**

Please sign below:

I hereby authorize my motor vehicle insurance carrier to release information to Professional Orthopaedic Associates regarding the PIP benefits that have been paid to date on my claim.

Signature: ______________________________ Date: ____________

I have reviewed these office policies and accept my responsibility as detailed above.

Signature: ______________________________ Date: ____________

I authorize my insurance company to make payments for my unpaid balance directly to:
Professional Orthopaedic Associates

I hereby authorize the release of information relating to my care directly to my insurance company, attorney, school, pharmacy or any other treating specialist.

Signature: ______________________________ Date: ____________

We welcome your referrals and look forward to a Doctor-Patient relationship.

Name______________________________ Date____________

PROFESSIONAL ORTHOPEDIC ASSOCIATES PHYSICAL THERAPY

CONSENT FOR OUTPATIENT TREATMENT

AUTHORIZATION:

I hereby authorize POA-TINTON FALLS health care professionals and students to provide such medical care and to administer such treatment, necessary to the named patient or me each time I or the named patient present to an ambulatory care service. Such procedures and treatments may include, Physical Therapy, Occupational Therapy & Speech Therapy. To the extent possible I have been informed of risks and complications that may occur and alternatives that may be available.

I acknowledge that no guarantees or assurances have been made to me concerning the results intended from my treatment.

MEDICARE PATIENTS:

I authorize any holder of medical or other information about me to be released to the Social Security Administration, its intermediaries, carriers and information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

GUARANTEE OF ACCOUNT:

For and in consideration of services rendered to (name) ________________________________ by POA-TINTON FALLS, I hereby agree to pay the full bill for all charges which are not paid to POA-TINTON FALLS by insurance carriers, Worker's Compensation, No-fault or any balance due which is not covered by insurance or excluded by a co-insurance clause.

RELEASE OF INFORMATION:

I permit POA-TINTON FALLS to disclose all or part of the above patient's medical records to any person, corporation, or agency when required for the collection of benefits or payment of POA-TINTON FALLS charges.

ASSIGNMENT OF BENEFITS:

I assign POA-TINTON FALLS all benefits from any corporation, agencies and person for these services. Additionally, I authorize payments of these benefits directly to POA-TINTON FALLS.

I confirm that I have read, and fully understand the above.

Site Location: ____

Patient/Relative or Guardian: ____

(Signature) (Print name)

Relationship (if signed by person other than patient) ____________________________________

PROFESSIONAL ORTOPEDIC ASSOCIATES
PHYSICAL THERAPY

To all Medicare patients,

Beginning January 1, 2013 there will be a cap of $1900 per year for Physical Therapy and Speech Pathology together. A separate cap of $1900 per year is allowable for Occupational Therapy.

Medicare will pay out a cap of 80% ($1520) of their allowable charges ($1900). And you the patient are responsible for your annual deductible of $147.00 and the 20% coins. of $380.00.

Please keep in mind that not all secondary policies will cover the 20% or additional visits after the cap has been reached for the current year.

During your treatment period at POA please check with the front desk to make sure you are not going over your therapy allowance. POA has put in place a pre-determined amount of visits that will give you the patient a comfort level to be able to make informed decisions whether to continue physical therapy according to your financial ability.

For clarification on your secondary policy benefits, please contact your carrier or please feel free to contact our business office regarding you benefit and financial obligations at: professional Ortho. Assoc. - Physical Therapy 732-741-0665.

Each beneficiary who uses therapy services will find the total dollar amount that was approved and paid toward the cap on each Medicare summary notice that reports payment for therapy services. Beneficiaries call 1-800-MEDICARE with questions.

Please sign and date the form that you have been informed of PROFESSIONAL ORTHO. ASSOC. – PHYSICAL THERAPY'S policy regarding the Medicare Cap.

____ ____________________
Patient Name (printed) Date

____
Patient Signature

POAPT

Physical Therapy

I give my consent to Professional Ortho. Assoc. – Physical Therapy physicians and staff to leave messages, discuss scheduling, treatment, surgery, or other information regarding my care as follows:

____ On voicemail at home

____ On voicemail at work

____ Cell phone

____ E-mail ______________________________

____

Signature of Patient or Representative

____

Date