Rehab Connection
'SICAL & OCCUPATIONAL THERAPY FOR ALL AGES

☐ 50 E. Gloucester Pike • Barrington, NJ 08007 856.547.4422 Fax: 856.547.0660
☐ 205 Madison Ave. • Lumberton, NJ 08060 609.261.3354 Fax: 609.261.8814
☐ Katz JCC, 1301 Springdale Rd. • Cherry Hill, NJ 08003 856.334.6160 Fax: 856.673.2589
☐ New Albany Professional Bldg., 2800 Route 130 North, Ste. 104 • Cinnaminson, NJ 08077 856.829.0499 Fax: 856.829.1899
☐ 204 Grove Avenue, Suite B • West Deptford, NJ 08086 856.433.6382 Fax: 856.433.6383
☐ Franklin Medical Arts Bldg., 181 W. White Horse Pike • Berlin, NJ 08009 856.335.8008 Fax: 856.335.8009
www.rehabconnection.org

Dear new patient,

We would like to take this opportunity to welcome you to **Rehab Connection**. We are confident that you will be completely satisfied with our facility as well as our staff.

We accept most insurance plans and our staff personally verifies your coverage prior to your first visit. You will be notified if there are any problems with your benefit plan.

Our Billing Department is available Monday through Friday from 10 am to 4 p.m. to answer any billing/insurance questions. Feel free to stop into the Barrington office or call the Billing Department at (856) 547-4422 x 304.

We have a therapist on staff daily as well as most evenings. Please feel free to call our therapists if you have any questions/concerns. Should you call when the therapist is not in the office, your call will always be returned upon receipt of the message.

Again, we would like to welcome you to **Rehab Connection**.

Sincerely,

Amy Knecht, PT, DPT, MHS, QA03869

Michele Warren, PT, DPT, MHS QA03884

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EXPLANATION OF MEDICARE COVERAGE

Medicare will allow a maximum payment of $2010.00 per calendar year for outpatient physical/speech therapy. This means, after your 2018 deductible of $183 has been met, Medicare will pay 80% and you will be responsible for the additional 20% if you do not have a secondary insurance.

Generally this allowance translates to approximately 15 visits depending on the type of service rendered. Medicare also requires each patient to have a prescription from your referring physician as well as a certified plan of care every 30 days.

Should you require additional therapy services once you have reached your maximum coverage allowance, your therapist will discuss other options for continued care with you. In the event you decide to continue treating with Rehab Connection, your insurance may not cover your treatment and you, the patient/patient's power of attorney will be financially responsible for these services.

If you have any questions, please feel free to contact our Billing Company at 914-366-6161.

PATIENT REGISTRATION FORM

Patient's Name:_____
Address: _____
_____
Date of Birth: _____

Home Phone #: _____
Cell Phone #: _____
Email Address:_____
Social Security #_____
Sex: Male Female

Name & Phone # of Emergency Contact:
_____

How did you hear about us? (Check ALL that apply) ☐ Physician☐ Friend/Family ☐ Website
☐ Other_____

Referring Physician: _____
Address: _____
_____
Phone #: _____

Primary Physician : _____
Address: _____
_____
Phone #: _____

IF INSURANCE IS OTHER THAN SELF: **Spouse Child Other**

Insured's Name: _____
Address: _____
_____
Phone #: _____

Date of Birth: _____
Social Security#: _____
Sex: Male Female

Primary Insurance Information:
Insurance Co: _____
Phone #: _____
Id / Policy #: _____
Group #: _____

Secondary Insurance Information:
Insurance Co: _____
Phone #: _____
Id / Policy #: _____
Group #: _____

- Have you received therapy at another facility? Y N
- If yes, please explain where, when, how many visits and for what injury?
- _____
- Is this injury post-surgical? Y N
- Is your injury a result of an automobile accident? Y N
- Is your injury a result of a work-related accident? Y N
- Is your injury a result of a slip and fall accident? Y N
- Is your injury a result of any other type of accident? Y N
- Do you have an attorney? Y N

Attorney's name: _____Telephone#:_____
Address: _____

If you answered yes to any of the above questions, please supply all listed documents that apply: police report, incident report, auto insurance card, insurance declaration page, driver's license, claim #, adjuster name and telephone #. (Additional information may be requested.)

INTAKE FORM REVIEWED BY: _____ (Rehab Connection Employee)

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ASSIGNMENT OF BENEFITS

I authorize payment of Medicare/Insurance benefits to be made directly to Rehab Connection on my behalf for physical/occupational therapy services rendered. I also authorize Rehab Connection to release my protected health information for treatment and billing purposes.

Initials _____

NOTICE OF PRIVACY PRACTICES

I have read Rehab Connection's Privacy Practice and if I wish to receive a paper copy, I know I have the right to request one.

Initials _____

FINANCIAL POLICY

As a courtesy, Rehab Connection will pre-verify your insurance benefits. If coverage is terminated during course of treatment, the fees will be patient's/guardian's responsibility.
Please note: Unless you have secondary insurance, all co-pays, deductibles, and/or co-insurance is the patient's/guardian's (in case of a minor) responsibility. Co-pays are due at the time services are rendered. Your deductible/co-insurance will be billed to you once we have received an "Explanation of Benefits" from your insurance carrier.

Balances older than 60 days will accrue interest at a rate of 1.5% per month. There is a $25 fee for returned checks. Collection and billing fees will be charged to any account billed multiple times.

*Payment methods include: cash, check, money order, Visa, MasterCard, and Discover.

Initials _____

MEDICARE PATIENTS:

I have been advised of the Medicare Cap for outpatient therapy services

Initials _____

CANCELLATION/NO-SHOW POLICY

Rehab Connection urges you to keep every appointment, as consistent treatment will increase a speedy recovery. We require 24 hours notice if you need to cancel an appointment. Patients who cancel without proper notice or fail to show up for scheduled appointments will be subject to $25 charge.

Initials _____

I have read and understand the above policies and procedures.

_____ _____
Patient's/Guardian Signature Date

_____ _____
Reviewed By Date

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To Our Patients:

Rehab Connection requests our patients keep a credit card on file. Your credit card information, as all of your private information, will be kept in a secure location and used only with your permission. Only co-pays, deductibles and co-insurance will be billed to your card. This will benefit you, our valued patient, in that you will not have to write multiple checks, keep track of multiple receipts, or receive multiple bills from our billing department

Payment on file, in no way compromises your right to dispute or question patient balances, non-covered charges, etc. Our staff, as always, is here to assist you with any questions or concerns you may have.

Sincerely,

Sharon
Accounts Receivable
856-547-4422 x 306

OPTION 1: I, _____, authorize Rehab Connection, PC to charge co-pays, deductible and/or co-insurance balances on my account to the following credit card:

___ Visa ___ MasterCard ___ Discover

Account Number _____ Exp Date _____

Authorized Signature _____ Date _____

OPTION 2: I do not authorize credit card charges at this time. I agree to pay co-pays at the time of service. I understand that returned checks and balances older than 60 days are subject to additional charges as stated in Rehab Connection's financial policy.

Print Name _____ Patient (if minor) _____

Signature _____ Date _____

OFFICE USE ONLY:

Office _____ Co-Pay _____

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Patient Disclosure Authorization Form

Patient Name: _____ Date of Birth: _____

I authorize disclosure of my protected health information to the individual(s) named below.

Name	Relationship to Patient
_____	_____
_____	_____
_____	_____

Description of information to be released: (please check all that apply)

- ☐ Appointment Times
- ☐ Medical Records Release
- ☐ Billing Information
- ☐ Other (specify):_____

This authorization provides that:

- ♦ I may revoke this authorization at any time, provided that my request is made in writing to Rehab Connection.
- ♦ Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by HIPAA rules and regulations.
- ♦ I have a right to access my protected health information that will be used or disclosed.
- ♦ I will receive a copy of this completed and signed authorization form.

Signature: _____ Date: _____

Relationship to patient (if signed by personal representative):

_____

Patient History Form

Date: _____ Name: _____ Diagnosis: _____

Age: _____ Gender: _____ Height: _____ Weight: _____

Family Physician: _____ Referring Physician: _____

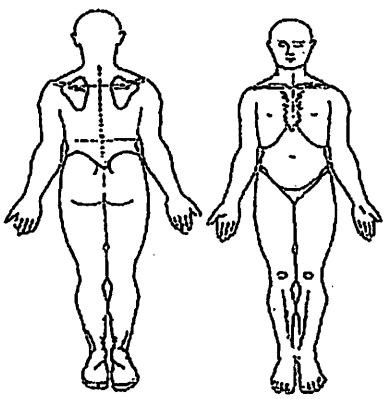
Date your problem first occured?: _____ Date of Surgery: _____

How did your problem first occur?: _____

Please check all that describe your symptoms:

constant		worse midday		dull		numbness		clicking		pressure	
intermittent		worse in pm		achey		burning		popping		locking	
worse in am		sharp		tingling		stabbing		grinding		heavy	

Please mark your symptoms on the body diagram below with and "X":



Do your symptoms keep you up at night? yes / no / sometimes

What increases your symptoms?: _____

What decreases your symptoms?: _____

Pain Scale: Please mark on the line the level of pain for each one.

Worst: no pain |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----| severe pain
0 1 2 3 4 5 6 7 8 9 10

Current: no pain |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----| severe pain
0 1 2 3 4 5 6 7 8 9 10

Best: no pain |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----| severe pain
0 1 2 3 4 5 6 7 8 9 10

Have you had treatment for this problem before? _____ If so, by whom?: _____

Have you had Physical Therapy for this problem before?: _____ If so, by whom?: _____

Have you had PT for any problem before?: _____ For what?: _____ When?: _____

Have you had x-rays, MRI or other tests for your current problem? yes / no If so, which? _____

My general health is (circle one): excellent / good / fair / poor

Prior to my injury, my activity level was (circle one): good / fair / poor

My current activity level is good / fair / poor (circle one)

Do you live alone?: yes / no

Have you fallen in the past year?: yes / no If so, how many times?: ____ When was the last fall?: ___

Do you have stairs in your home?: yes / no How many?: ____ Is there a railing?: yes/no

Please check any of the following medical conditions that apply to you:

Osteoarthritis		Cancer/Hx of Cancer		Heart Conditions		Seizures	
Rheumatoid arthritis		Pulmonary Conditions/Asthma		Hiatal Hernia		Pregnant	
Diabetes (Type I/ II)		Parkinson's Disease		Pacemaker		Blood Pressure	
Visual Impairments		Osteoporosis/Osteopenia		Multiple Sclerosis		Other (explain)	

Please circle each of the following (if any) that you are currently under the care of:

behavioral health specialist / neurologist / pain management physician / dietician / chiropractor?

Medications: Please list or provide a list of all current medications. Please include dosage, frequency and how taken if other than orally for all over the counter, prescription and vitamin/mineral supplements.

Medication	dosage	Medication	dosage	Medication	dosage

What is your highest level of education?: _____

Occupation: _____ Are you currently working?: yes / no

Job activities: _____ Is light duty available?: yes / no

Hobbies: _____

Please list 3 activities you want to be able to do but are currently restricted from doing because of your current problem. Please also list your pain level (0-10) while trying to complete each.

1. _____ Pain level: ____
2. _____ Pain level: ____
3. _____ Pain level: ____

What are you UNABLE to do now because of your problem that you need/want to be able to do?:

_____

In what time frame would you like to see the above goals achieved?: _____