Advanced Physical Therapy of South Jersey

1035 North Blackhorse Pike #5 Williamstown, NJ 08094 (856-728-4100)
660 Woodbury-Glassboro Rd. Ste #19 Sewell, NJ 08080 (856-415-1400)

New Patient Registration

Date_____

Patient Name: Last_____ First_____

Address_____

City_____ State_____ Zip _____

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

Date of Birth_____ Social Security#_____

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

Emergency Contact Name_____Phone_____

Employer_____ Phone#_____

Employer Address_____

City_____ State_____ Zip Code_____

Attorney Information

Attorney Name_____Name of Law Firm_____

Address_____

City_____State_____Zip_____Phone#_____

Date of Injury_____Accident Insurance Company_____

Address_____

City_____State_____ZipCode_____Phone#_____

Name of Insured_____Relationship to Patient_____

Claim#_____Policy#_____

Release: I hereby authorize the release of any information acquired in the course of my examination which said insurance company may request. **Patient responsibility & Assignment:** I also assign & request payment of medical benefits to the above stated provider for medical services. I am responsible for providing ALL insurance coverage at the time of each visit & immediately notifying us of any changes in medical coverage. Failing to provide active insurance cards for both primary and secondary insurance will result in my financial responsibility for any outstanding balance. 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. In the event that I have been involved in a motor vehicle accident, I understand that it is my responsibility to submit any balances due to my health insurance provider that have not been paid thru my motor vehicle insurance carrier. I also understand it is my responsibility to pay for any co-pays and/or deductibles to Advanced Physical Therapy of South Jersey at the time of receipt.

As a courtesy we will bill your insurance company. **X**_____

Guarantor/Parent/Guardian Signature

Patient Name_____ **Date**_____

Date of your next physician's visit_____

1. Date of Onset/Injury_____
2. Have you ever had these symptoms before?_____ Pain Level (0-10) _____
3. 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	___	___	Osteoarthritis	___	___
High Blood Pressure	___	___	Osteoporosis	___	___
Heart Disease	___	___	Hernia	___	___
Heart Attack	___	___	Dizziness/Fainting	___	___
Heart Palpitations	___	___	Fractures	___	___
Headaches	___	___	Surgeries	___	___
Kidney Problems	___	___	Cancer	___	___
Stroke	___	___	Rheumatic Arthritis	___	___
Asthma/Breathing Problems	___	___	Other Problems	___	___

4. Are you presently taking any Medication? Yes No

   If yes, please list what medications and for what condition:_____

_____

Signature_____

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

Advanced Physical Therapy of South Jersey

Patient Name_____

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 describe for me my individual treatment plan. 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 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 physical therapist. I authorize the release of medical information to my physician(s) or to my insurance carrier in order to process any claims.

Motor Vehicle Accident Release

If applicable, I knowingly and voluntarily assign Robert J Romalino P.T., P.C. doing business as Advanced Physical Therapy of South Jersey my rights and benefits under my health and/or automobile PIP policy the professional and/or medical expenses incurred by me for medical services rendered. I hereby authorize Robert J Romalino P.T., P.C. to sue my insurance company for reimbursement of incurred fees as a result of the subject treatment, including but not limited to the filing of a PIP Claim in the courts for arbitration using an attorney of their choice. I acknowledge that Robert J Romalino P.T., P.C. would be pursuing this claim on my behalf, and that this does not negate my responsibility to pay Robert J Romalino P.T., P.C. for their services over and above any recovery against the insurance company.

Notice Of Attendance Requirements

I have been advised of my responsibility toward my commercial insurance claim with Robert J. Romalino P.T., P.C. doing business as Advanced Physical Therapy of South Jersey. 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 will also understand that both my doctor and employer/insurance company may be notified. Furthermore, a **$25.00 charge** could be assessed to you the patient and your rehabilitation may be adversely effected. I also may be discharged from physical therapy due to lack of compliance.

Health Insurance Disclaimer

I understand that Advanced Physical Therapy has attempted to verify the eligibility and benefits of my health insurance coverage. They have explained to me my health insurance benefits as explained to them by a representative of my insurance company. I also understand that they have no way to verify its accuracy as reported to them. Furthermore, I understand that ultimately it is my responsibility to know my insurance coverage, which includes but not limited to Co-Pays and Deductible Information. In the event of an error in verifying coverage by Advanced Physical Therapy, **I understand it is still my responsibility to know my insurance coverage and it is my financial responsibility to make payments when an outstanding balance exists.** Advanced Physical Therapy will setup a payment plan for Co-Pay or Deductible Payments but if this balance is ignored we will forward it to a reputable collection agency. Advanced Physical Therapy has always verified insurance eligibility and benefits as a courtesy to our patients however recently the insurance company representatives have provided us with inaccurate information. In turn, we have relayed that misinformation to you which has led to unexpected bills from us. Please, check your insurance information to verify its accuracy. We can only assume that the information provided by your insurance company representative is correct although many times it is not.

Signature_____ Date_____