NORTH RIVER THERAPY

NEW PATIENT INFORMATION

Who can we thank for referring you to us? Check all that apply:

- ☐ Physician
- ☐ Friend/Word of Mouth: _____
- ☐ Google Search
- ☐ Worker's Compensation
- ☐ Case Manager/Discharge Planner
- ☐ Other: _____

NORTH RIVER THERAPY PATIENT INFORMATION

PREFERRED METHOD FOR APPOINTMENT REMINDERS: (CIRCLE ONE): EMAIL VOICE TEXT PLEASE INDICATE WHICH EMAIL/NUMBER TO USE. _____	Are you currently receiving Home Health? YES NO Have you received Home Health in the past 30 days? YES NO Have you received physical therapy this year? YES NO

PATIENT INFORMATION

Last Name:	**First:**	**Middle:**

D.O.B. _____/_____/_____	**Gender:** Male Female	

Address:	**City:**	**State:**	**Zip:**

Home Phone #: (_____)-_____-_____	**Cell Phone #:** (_____)-_____-_____	**Email Address:**

INSURANCE INFORMATION

Policy Holder (if different from patient):	**Relationship to patient:**	**Policy Holder D.O.B. (if different from patient):**

EMERGENCY CONTACT

Name:	**Relationship:**	**Phone #:**

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RELEASE OF INFORMATION

I, _____, authorize North River Therapy to use, release or disclose my healthcare information for treatment, payment or for healthcare operations to the following family members and friends. This authorization will remain in effect unless revoked by me in writing.

NAME	RELATIONSHIP	PHONE NUMBER
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____

_____

Signature Date

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PATIENT MEDICAL HISTORY

Name: _____ Referring Physician: _____

Date of Injury: _____ Date of Next Dr. Visit: _____

Describe your current symptoms: _____

What are your treatment goals? _____

PLEASE CIRCLE ONLY THOSE THAT APPLY

Anemia	Depression	Lung Problems
Anxiety/Panic Attack	Diabetes	Lyme's Disease
Arthritis/Joint Pain	Diarrhea/Nausea/Vomiting	Osteoporosis
Artificial Joints	Emphysema/Asthma	Pacemaker
Bladder Incontinence	Fainting Disorders	Polio/Muscle Disease
Bleeding/Bruising	Fibromyalgia	Pregnant
Blood Disorders	Gynecological Disorders	Seizures
Bowel Incontinence	Hepatitis	Shortness of Breath
Cancer/Tumors/Growths	High Blood Pressure	Spinal Cord Injury
Chest Pains/Heart Attack	High Cholesterol	Swelling of Extremities
Chills/Fever	History of Smoking	Thyroid Problems
Chronic Fatigue Syndrome	Hypoglycemia	TMJ Disorders
Chronic/Migraine Headaches	Kidney Disease/Stones	Traumatic Brain Injury
Concussion	Lightheadedness/Dizziness	Unexplained Weight Loss

Rate your current pain 0-10: _____ _____ _____

(0 is no pain & 10 is unbearable) at worst current at best

Please answer the following questions if applicable:

1. Please describe your pain (circle): sharp, burning, dull/achy, throbbing, or numbness/tingling
2. Please describe the frequency of your pain (circle): constant or intermittent
3. What relieves your pain? (rest, medication, etc.): _____
4. What makes your pain worse? (sitting, lifting, bending, etc.): _____

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PATIENT MEDICAL HISTORY

Drug Allergies: _____

Surgical History: _____

Please list X-RAYs, MRIs, OR CAT SCANs done in the past 6 months. (Include Area & Date):

_____

_____

Please list ALL current medications, along with dosage and frequency.

MEDICATION	DOSAGE	FREQUENCY

I certify that all information provided is complete and accurate. No essential information has been omitted.

Patient/Guardian Signature Date

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CONDITIONS OF ADMISSIONS

CAREFULLY READ ALL SECTIONS BELOW

AUTHORIZATION FOR TREATMENT

I hereby authorize and request treatment by the North River Therapy staff. My signature below indicates that I accept financial responsibility for all treatments and supplies not covered by insurance, which may consist of co-pays and deductibles. I also agree to pay all costs, expenses and attorney's fees incurred by North River Therapy or its authorized agent in collecting sums due. There is a $25 fee on all returned checks.

RELEASE OF INFORMATION

I do hereby request and authorize North River Therapy to obtain/disclose all or any part of my patient records to affiliated organizations of North River Therapy who are liable for all or any part of the patient's bill including but not limited to physicians, insurance companies, worker's compensation carriers or the patient's employer.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign and authorize direct payment to North River Therapy of all insurance benefits payable under the terms of any insurance policy for the services rendered. I remain responsible (unless otherwise provided by law) for any portion of the bill not paid by insurance.

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO NORTH RIVER THERAPY

I request that payment of authorized Medicare benefits be made on my behalf for any services furnished by North River Therapy. I certify that the information given by me is correct. I authorize any holder of medical or any other information about me to release to North River Therapy any information needed to determine these benefits.

INSURANCE COVERAGE INFORMATION

I have been advised that while most insurance carriers cover outpatient therapy costs under the major-medical provisions in their policies, which in most cases require that the patient pay a deductible before the insurance company will begin paying benefits. After the patient pays the deductible, the remaining balance is then partially paid by the insurance company. This amount is usually 80% of the bill and the remaining 20% co-pay is the responsibility of the patient. Please be aware the amount and extent of said coverage varies from policy to policy and that your deductible and co-pays may be different from the above described. I realize that there may be unmet deductibles or co-payments due under the terms of my insurance policy and that I will be responsible for the payment of the same once services have been rendered. If you are not sure of your benefits, please contact your insurance company.

AUTOMOBILE ACCIDENTS

It is understood and agreed that it is my responsibility to pay out of pocket for any charges I may accrue while at North River Therapy. It is then my responsibility to coordinate my therapy bills with whomever is handling my automobile accident for possible reimbursement to me.

PERSONAL VALUABLES

It is understood and agreed that North River Therapy is not responsible for loss or damage to any personal valuables or properties.

I have read the above information and understood that I am responsible for any/all incurred amounts not covered by insurance.

_____

Signature Date

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No Show/Cancellation Policy

Thank you for choosing North River Therapy as your physical therapy provider! We are sincerely dedicated in assisting you to meet **your** therapy goals. To do this, it is important you attend all scheduled therapy appointments.

Your appointment time has been specifically reserved for you to serve your physical therapy needs. If you are unable to attend a scheduled appointment, please notify us at least 24 hours ahead of time. We understand unexpected circumstances will occur, but we still ask that you give us as much notice as possible so we can reschedule your appointment; allowing other patients needing treatment to be accommodated.

To enforce this policy, you will be charged a $50 cancellation fee if you cancel an appointment less than 24 hours before your appointment. Your insurance does not cover charges for late cancellations or no-shows, it is patient responsibility.

If you are late for an appointment, you will be seen as soon as possible, though the visit may need to be shortened. In the instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care and inform your physician of the discontinuance due to non-compliance with your plan of care.

If you know you are going to have a difficult time making your appointments, please discuss this with the therapist or front office. We will do our very best to accommodate your needs. Thank you for your consideration!

I understand North River Therapy's appointment cancellation policy and understand my responsibility to plan appointments accordingly and notify North River Therapy appropriately if I have difficulty fulfilling my scheduled appointments.

_____

Patient Signature *Date*

_____

Witness Signature *Date*