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 - If YES, with whom? _____ Have you received Home Health in the past 30 days? YES NO - If YES, with whom? _____ 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 #:**

NORTH RIVER
THERAPY

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

NORTH RIVER
THERAPY

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.): _____

NORTH RIVER
THERAPY

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

NORTH RIVER
THERAPY

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

NORTH RIVER
THERAPY

No Show/Cancellation Policy

Our goal at North River Therapy is to ensure that we return you to the best possible pain control and function. In order to do that, we need to see you on a regular basis.

We have made a commitment to give you the highest care possible, and your appointment time has been specifically reserved for you to serve your physical therapy needs. If you give us at least 24 hours' notice we usually can fill the appointment, but if we do not hear from you, no one can take your place.

So, in order to get you back to the things you love, and in order for us to keep our costs down, we have a policy that if you cancel OR "no show" 3 times in 30 days, you will be discharged. You can return after getting another referral from the doctor. Think of this as our commitment to get you better!

Please also be aware that North River Therapy will charge a **$45 fee for appointments not cancelled at least 24 hours before your appointment.** We will make exceptions for true emergencies, of course.

Should there be any time you do not cancel and do not come to your scheduled appointment without notifying our office, **you will be charged a No-Show fee of $75.** Please understand we do not charge this lightly, we simply must account for the time we have the therapists scheduled for your treatment.

Your insurance does not cover charges for late cancellations or no-shows, it is patient responsibility.

I have read and understand the cancellation policy. I recognize that my attendance and follow-through with therapy will directly affect my results.

Patient/Guardian Signature *Date*

Printed Name of Patient or Guardian *Date*