Holistic Manual Physical Therapy
The Australian Method A Touch of difference.

PalPark Physical Therapy
The Australian Method A Touch of difference.

REGISTRATION

Date _____

Patient _____ Home Phone _____
Last Name First Name M.I.

Street Address _____

_____
City State Zip

Sex ❑ M ❑ F Age _____ Birth Date _____ Social Security # _____

Marital Status ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Spouse's Name _____ Phone _____

Condition Related To ❑ Illness ❑ Employment ❑ Auto ❑ Other

Employer Name _____ Occupation _____

Employer Address _____ Phone _____

Primary Insurance

Please check the insurance coverage applicable in this case.
❑ Medicare ❑ Major Medical ❑ Auto Accident ❑ Worker's compensation ❑ Other

Insurance Company Name _____ Phone _____

Address _____

Policy Holder Name _____ Effective Date _____

Birth Date _____ Social Security # _____

Policy # _____ Group # _____

Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other

Date of Accident _____ Claim # _____

Adjuster _____ Phone _____

Secondary Insurance

Insurance Company Name _____ Phone _____

Address _____

Policy Holder Name _____ Effective Date _____

Policy # _____ Group# _____

Holistic Manual Physical Therapy
61 Grand Avenue
Englewood, NJ 07631

Phone: 201.568.2044
Fax: 201.568.7455

General Consent for Care and Treatment Consent

TO THE PATIENT: *You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).*

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your therapist about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	Date
Printed Name of Patient or Personal Representative	Relationship to Patient
Printed Name of Witness Employee	Job Title
Signature of Witness	Date

Holistic Manual Physical Therapy
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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name:_____

Date of Birth: _____Social Security #:_____

By signing this form, you acknowledge that we have provided you with our Notice of Privacy Practices which explains how your health information may be handled in various situations including your treatment, payment of your bill, and our healthcare operations. If your first date of service with us was due to an emergency, we will try to provide you with our Notice and get your written acknowledgement for the Notice as soon as we can once the emergency has passed.

[ ] I have received the Notice of Privacy Practices (effective date _____).

_____ _____
Patient's (or Legal Representative's) Signature) Date

_____
Relationship of Legal Representative

For office use only
To be completed only if Acknowledgement is not signed.

1) Was the patient given a copy of the Notice of Privacy Practices?
   [ ] Yes [ ] No

2) Please explain why the patient was unable to sign this Acknowledgement and our efforts to try to obtain the patient's signature:

_____
_____
_____
_____
_____
___

_____ _____
Name/Title Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Our Duty to Safeguard Your Protected Health Information.

We understand that medical information about you is personal and confidential. Be assured that we are committed to protecting that information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. We are required by law to abide by the terms of this Notice, and we reserve the right to change the terms of this Notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised notice and make paper and electronic copies of this Notice of Privacy Practices for Protected Health Information available upon request. We are required by law to notify you in the event of a breach of your protected health information.

In general, when we release your personal information, we must release only the information needed to achieve the purpose of the use or disclosure. However, all of your personal health information that you designate will be available for release if you sign an authorization form, if you request the information for yourself, to a provider regarding your treatment, or due to a legal requirement. We will not use or sell any of your personal information for marketing purposes without your written authorization.

II. How We May Use and Disclose Your Protected Health Information.

For uses and disclosures relating to treatment, payment, or health care operations, we do not need an authorization to use and disclose your medical information:

For treatment: We may disclose your medical information to doctors, nurses, and other health care personnel who are involved in providing your health care. We may use your medical information to provide you with medical treatment or services. For example, your doctor may be providing treatment for one medical condition and need to contact another of your doctors to make sure that you don't have any other health problems that could interfere. The doctor might use your medical history to determine what method of treatment (such as a drug or surgery) is best for you. Your medical information might also be shared among members of your treatment team, or with your pharmacist(s).

To obtain payment: We may use and/or disclose your medical information in order to bill and collect payment for your health care services or to obtain permission for an anticipated plan of treatment. For example, in order for Medicare or an insurance company to pay for your treatment, we must submit a bill that identifies you, your diagnosis, and the services provided to you. As a result, we will pass this type of health information on to an insurer to help receive payment for your medical bills.

For health care operations: We may use and/or disclose your medical information in the course of operating our practice. For example, we may use your medical information in evaluating the quality of services provided, or disclose your medical information to our accountant or attorney for audit purposes.

In addition, unless you object, we may use your health information to send you appointment reminders or information about treatment alternatives or other health-related benefits that may be of interest to you. For example, we may look at your medical record to determine the date and time of your next appointment with us, and then send you a reminder to help you remember the appointment. Or, we may look at your medical information and decide that another treatment or a new service we offer may interest you.

Furthermore, we may want to use information found in your medical record, such as your name, address, and phone number, to contact you for our fundraising purposes. For example, in order to provide more charity care or otherwise improve the health of your community, we may want to raise additional money and therefore may contact you for a donation. You have the right to opt out of these communications at any time.

We may also use and/or disclose your medical information in accordance with federal and state laws for the following purposes:

- We may disclose your medical information to law enforcement or other specialized government functions in response to a court order, subpoena, warrant, summons, or similar process.
- We may disclose medical information when a law requires that we report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. We must also disclose medical information to authorities who monitor compliance with these privacy requirements.
- We may disclose medical information when we are required to collect information about disease or injury, or to report vital statistics to the public health authority. We may also disclose medical information to the protection and advocacy agency, or another agency responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents
- We may disclose medical information relating to an individual's death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
- In certain circumstances, we may disclose medical information to assist medical/psychiatric research.
- In order to avoid a serious threat to health or safety, we may disclose medical information to law enforcement or other persons who can reasonably prevent or lessen the threat of harm, or to help with the coordination of disaster relief efforts.
- If people such as family members, relatives, or close personal friends are involved in your care or helping you pay your medical bills, we may release important health information about you to those people We may also share medical information with these people to notify them about your location, general condition, or death.
- We may disclose your medical information as authorized by law relating to worker's compensation or similar programs.
- We may disclose your medical information in the course of certain judicial or administrative proceedings.

Other uses and disclosures of your medical information not covered by this notice (such as for marketing purposes) or the laws that apply to us will be made only with your written authorization. If you provide permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided you.

III. Your Rights Regarding Your Medical Information.

You have several rights with regard to your health information. If you wish to exercise any of these rights, please contact our Privacy Officer. Specifically, you have the following rights:

- You have the right to ask that we limit how we use or disclose your medical information. For example, for services you request no insurance claim be filed and for which you pay privately, you have the right to restrict disclosures for these services for which you paid out of pocket. You have the right to ask that we send you information at an alternative address or by an alternative means. We will consider your request, but are not legally bound to agree to the restriction. We will agree to your request as long as it is reasonably easy for us to do so. To request confidential communications, you must make your request in writing to the office address listed above. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted.
- With a few exceptions (such information gathered for judicial proceedings), you have a right to inspect and copy your protected health information if you put your request in writing. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. We may charge you a reasonable fee if you want a copy of your health information. You have a right to choose what portions of your information you want copied and to have prior information on the cost of copying.
- If you believe that there is a mistake or missing information in our record of your medical information you may request that we correct or add to the record. Your request must be in writing and give a reason as to why your health information should be changed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide,

appended to your medical information. If we approve the request for amendment, we will amend the medical information and so inform you.

- In some limited circumstances, you have the right to ask for a list of the disclosures of your health information we have made during the previous six years. The list will not include disclosures made to you; for purposes of treatment, payment or healthcare operations, for which you signed an authorization or for other reasons for which we are not required to keep a record of disclosures. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

- You have a right to receive a paper copy of this Notice. We will provide you with a paper copy or email of the Notice upon request.

IV. Questions and Complaints:

If you want more information about our privacy practices or have questions or concerns, we encourage you to contact us.

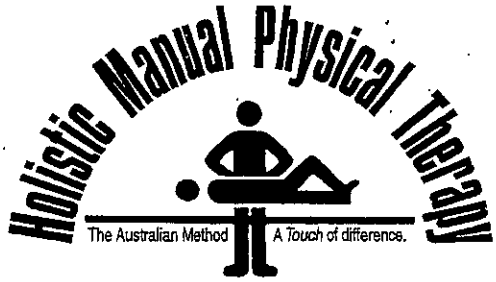
If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, we encourage you to speak or write to our Privacy Officer. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services at the Office for Civil Rights' Region IV office. We will provide the mailing address at your request.

We will take no retaliatory action against you if you make any complaints, whether to us or to the Department of Health and Human Services. We support your right to the privacy of your health information.

If you have questions about this Notice or any complaints about our privacy practices, please contact our Privacy Officer, either by phone or in writing at

V. Effective Date: _____

Nachum Loss, PT, MS, GDAMT
Fellow of The American Academy of Orthopedic Manual Physical Therapists
Co-Director



Margaliet Themans-Loss, PT
Co-Director

Patient Reports Release Letter

X I _____, hereby give permission to your facility to release copies of my examination report to the following:

Holistic Manual Physical Therapy
61 Grand Avenue
Englewood, NJ 07631
T. (201) 568-2044 F. (201) 568-7455

I accept full responsibility for the accuracy of the above address and or fax number, as it is integral to the transfer of the medical information contained in my personal reports.

X Patient Name: _____
X D.O.B._____
X SSN._____

** If you have any questions regarding this request please contact our office and speak to our privacy officer

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PATIENT QUESTIONAIRE

Name/Nombre: _____ Weight/Peso: _____ Height/Altura: _____

As a result of the condition do you suffer from pain or discomfort when performing the following activities? (Please circle)

1. Bathing
2. Grooming
3. Lifting arms to comb hair
4. Housecleaning
5. Putting on socks / shoes
6. Eating, chewing, talking, and other oral activities
7. Dressing
8. Cooking
9. Standing
10. Sitting
11. Bending
12. Climbing
13. Twisting
14. Lifting
15. Walking
16. Exercising
17. Sexual performance
18. Grasping
19. Opening jars
20. Holding objects with hands
21. Loss of sensory discrimination
22. Difficulty falling asleep
23. Inability to turn in bed
24. Pain causing patient to awaken frequently
25. Long walks
26. Bike rides
27. Sports (list all) _____
    _____
28. Other: _____
    _____

Sufre de dolor, incomodidad cuando hace las siguientes actividades?

1. Bañar
2. Asear
3. Levantar los brazos para peinar
4. Limpiar la casa
5. Ponerse las medias / zapatos
6. Comer, masticar, hablar, y otras actividades orales
7. Vestirse
8. Cocinar
9. Mantenerse de pie
10. Estar sentado
11. Doblarse
12. El escalamiento
13. La torsedura
14. Levanter
15. Caminar
16. Ejercicios
17. El desempeño sexual
18. Agarar
19. La aperture de taros
20. Aguantar objetos con las manos
21. La perdida de discriminacion sensitividad
22. La dificultad de caer dormida
23. Incapacidad de moverse en cama
24. Dolor que le ocasiona despertar frequentemente
25. Caminatas largas
26. Montar bicicletas
27. Deportes: _____
    _____
28. Otros: _____
    _____

Signature / Firma: _____ Date/ Fecha: _____

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) ☐ YES ☐ NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.