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# _____

Medical & Legal Information	
	Attorney _____ Phone _____
	Address _____
	Referring Doctor _____ Phone _____
	Known Medical Problems _____
	Family Physician _____ Phone _____
	Pregnant ☐ Yes ☐ No Pacemaker ☐ Yes ☐ No
	In Case of Emergency, Contact
	Name _____ Relationship _____
	Home Phone _____ Work Phone _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Nachum Loss, PT/ Manual Physical Therapy all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the therapist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient Signature _____ Date _____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made be on my behalf to Nachum Loss, PT/ Manual Physical Therapy for any services furnished me by that therapist. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

As a Medicare patient, I am aware that my insurance company requires me to have an updated prescription every thirty days. These thirty days become effective from the exact date in which my prescription was written by my doctor. I am responsible for keeping an updated prescription while treating for physical therapy in order not to be responsible for payment.

Patient Signature _____ Date _____

Holistic Manual Physical Therapy
61 Grand Avenue
Englewood, NJ 07631

Phone: 201.568.2044
Fax: 201.568.7455

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Holistic Manual Physical Therapy For the purpose of diagnosing or providing treatment to me or my dependent(s), obtaining payment from y insurance carrier and or to conduct business operations with any subsidiary affiliations of Holistic MPT, concerning y treatment. I understand that diagnosis or treatment of me by a therapist of Holistic MPT may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction in writing as to how my protected Heath information us used or disclosed to carry out treatment, payment or healthcare operations of the practice. However, HMPT is not required to agree to the restrictions that I may request. If Holistic MPT agrees to a restriction that I request, the restriction is binding on HMPT and its practitioners.

As a patient treating at HMPT, I have the right to revoke this consent, in writing, at anytime, except to the extent that HMPT has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, anther heath care provider, healthcare plan, my employer, my attorney, or my health-clearing house. This protected health information relates to all my physical therapy treatment or condition that identifies me.

I have received and will review HMPT Notice of Privacy, which explains my rights as a healthcare consumer and HMPT duties with respect to my protected health information. If I have any concerns I will contact HMPT privacy officer for further information.

**If HMPT staff has to call me to reschedule, cancel an appointment or leave me a message regarding my treatment, I authorize HMPT staff to contact me at the number(s) I have provided to them. If I do not wish for the staff to leave me a message on may machine or with anyone other than myself, I will advise then of it and list my restrictions.

Restrictions: _____

_____

Signature of Patient or Representative: _____

Date: _____ **Relationship to Patient:** _____

***HMPT reserves the right to change or edit the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised copy by contacting the staff and requesting one.

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CONDITIONAL ASSIGNMENTS OF BENEFITS AND GUARANTEE TO COOPERATE

This Limited Assignments of Rights and Guarantee to Cooperate is made between Holistic Manual Physical Therapy. Having offices located at 61 Grand Avenue; Englewood, NJ 07631, herein after referred to as the "Provider", and the following individual, herein after referred to as the "Patient"

Name of Patient: _____

Address: _____

_____

_____

In consideration of services rendered, the Patient authorizes these Conditional Assignments of Rights and Guarantee to cooperate to the benefit of the Provider. The patient agrees to the following Terms and Conditions:

- ❑ The Patient assigns directly to the Provider the payment of, and the right to collect payment of any no-fault automobile insurance benefits to which the Patient may be entitled for services rendered by the Provider.

- ❑ Pre-Certification: The Patient and the Provider agree to comply with any policy terms concerning pre-certification of treatment, which may include a decision pint review. The Provider agrees to hold the patient harmless for any co-pay penalty, which may be imposed for the failure of the Provider to comply with a pre-certification plan.

- ❑ The Patient authorizes, assigns and directs payment of no-fault insurance carrier (the "carrier") named in this paragraph no. 2 for the payment of no-fault medical benefits to which the Patient is entitled in accordance with the applicable provisions of the following insurance policy:

Name of Insurance Carrier: _____

Policy Number: _____

- ❑ In the event that the Patient fails to file an application for benefits under the New Jersey State no-fault laws, and the Provider has not been paid by the carrier for medical services rendered to the Patient, the Provider is hereby authorized to file and application on the Patient's behalf in order that the Provider released payment.

- ❑ Guarantee: The Patient agrees to fully cooperate with the Provider's efforts to prosecute a claim against the no-fault insurance carrier in the event timely payment of medical benefits is not made to the Provider for services rendered.

- ❑ This Limited Assignment of Rights and Guarantee to cooperate shall be deemed a "limited assignment the Provider solely for the purpose of collecting payment from the carrier for medical services rendered.

Approved and Agreed By: Patient: _____

_____ Date: _____

WITNESS

Holistic Manual Physical Therapy
61 Grand Avenue
Englewood, NJ 07631

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Fax: 201.568.7455

VOLUNTARY PHYSCIAN'S LIEN

I hereby provide an irrevocable lien to the therapist named above against any settlement, judgment or verdict arising out of my accident on the date of _____.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I further instruct that in the event, another attorney is substituted in this matter, the new attorney shall honor this lien and deem plaintiff enforceable as if it were executed by him.

Upon settlement, judgment, or verdict and prior to disbursements of any fund to myself, I here by direct my attorney to pay to the therapist stated above any and all sums that may be due and owing to said therapist.

Furthermore, I understand that I am primarily responsible to the therapist for any and all bills that I incur. I have been advised that if my attorney does not wish to cooperate in protection the therapist's fees the therapist will not await payment, but will require me to make payments each time I receive treatment.

Date: _____

Patient's Signature: _____

Attorney consent

As the attorney of the record with respect to the above captioned matter, I hereby agree to honor and observe all the terms of the above voluntary physician's lien and assignment of benefits of the above therapist for the resolutions of the matter of change is legal representation.

Date: _____

Attorney's signature: _____

PLEASE SIGN, DATE AND RETURN THE ORIGINAL TO THE THERAPIST'S OFFICE.

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❑ I understand that when and if my motor vehicle insurance company notifies me that I have been terminated of my medical benefits as a result of any *INSURANCE MEDICAL EXAMINATION (IME)*, I am fully responsible to notify Holistic Manual Physical Therapy of such. I understand that I am fully responsible for any paid bills after I have been terminated from my benefits.

❑ I also understand that I cannot and will not treat with any chiropractor or physical therapist on the same day for the same conditions I am treating with Holistic Manual Physical Therapy. I will be fully responsible for charges incurred that my insurance carrier does not reimburse Holistic Manual Physical Therapy on my behalf, if I treat with a chiropractor or another physical therapist.

Patient Signature: _____

Date: _____

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

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

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: _____