ARS Hand and Physical Therapy
505 Morris Avenue, Suite 103
Springfield, NJ 07081

PLEASE COMPLETE ALL INFORMATION

HOW DID YOU HEAR ABOUT US? ☐ PHYSICIAN ☐ FRIEND ☐ AD/POSTCARD/INTERNET SEARCH ☐ Other

PHYSICIAN/FRIEND (NAME) _____

PATIENT EMAIL ADDRESS _____

LAST NAME _____ **FIRST** _____ **MIDDLE** _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

DATE OF BIRTH _____ AGE _____ SEX _____

MARITAL STATUS MARRIED_____ SINGLE _____ DIVORCED_____WIDOWED_____

EMPLOYER _____

OCCUPATION _____ FULL TIME _____ PART-TIME _____ RETIRED _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____

ID NUMBER _____ GROUP NO _____

SUBSCRIBER'S NAME IF DIFFERENT FROM PATIENT _____

RELATIONSHIP TO PATIENT SELF_____ SPOUSE _____ PARENT _____ OTHER _____

INSURED'S DATE OF BIRTH IF NOT PATIENT _____

SECONDARY INSURANCE _____

ID NUMBER _____ GROUP NO _____

SUBSCRIBER'S NAME IS DIFFERNET FROM PATIENT _____

RELATIONSHIP TO PATIENT SELF _____ SPOUSE _____ PARENT _____ OTHER _____

INSURED'S DATE OF BIRTH IF NOT THE PATIENT _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS ALL CLAIMS.
I AUTHORIZE THE PAYMENT OF MEDICAL BENEFITS TO ARS HAND AND PHYSICAL THERAPY FOR SERVICES RENDERED.

SIGN _____ **DATE** _____

I HAVE RECEIVED MY NOTICE OF PRIVACY POLICIES FROM ARS HAND AND PHYSICAL THERAPY

SIGN _____ **DATE** _____

Our office will submit your claims to your carrier for payment. Please do not submit this claim yourself. If there is any deductible or coinsurance due to this office that has not been paid, a statement will be forwarded to you reflecting this amount. You will also receive an Explanation of Benefits from your carrier describing your claims. If there are monies due from you, this office will bill you accordingly. Should the reimbursement check come directly to you, please forward it to this office within ten (10) days.

There will be a $30.00 returned check fee for any checks that are returned to this office. Should your account be placed in collection, a collection agency fee up to fifty percent (50%) will be added to the amount due and all three credit reporting agencies will be notified.

By signing this statement, you agree to reimburse ARS Hand and Physical Therapy for any monies you received from your insurance carrier.

SIGN _____ **DATE** _____

NO SHOW/ CANCELLATION POLICY

At ARS Hand and Physical Therapy your care is our priority. We book fewer patients than the industry standard to give you the time you need to address all your needs. We do not overbook patients. A cancellation with less than 24 hours notice is devastating to us. For this reason we have a $50.00 cancellation fee for appointments that are cancelled within 24 hours of their scheduled appointment time.

SCHEDULING

To ensure you get the appointment times you need, we encourage you to schedule out your entire plan of care at the time of your first visit. If additional visits are needed beyond what was initially scheduled, you will be responsible for scheduling those visits. We cannot hold spots, if they are not formally scheduled with the front desk.

SIGN _____ **DATE** _____

PATIENT CONFIDENTIALITY

In this office, **Patient Confidentiality** is a prime concern. Due to confidentiality regulations, should a family member, friend, or relative contact our office, we are not at liberty to discuss your situation unless we have permission from you, the patient. Please identify whom we may discuss your situation.

Name _____
Relationship _____
Phone _____

Name _____
Relationship _____
Phone _____

FOR MEDICARE PATIENTS ONLY

I REQUEST THAT MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO ADVANCED REHAB SOLUTIONS FOR ANY SERVICES FURNISHED TO ME BY THAT PROVIDER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE CENTERS FOR MEDICARE & MEDICAID SERVICES AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES:

SIGN _____ **DATE** _____

I REQUEST PAYMENT OF AUTHORIZED MEDIGAP BENEFITS BE MADE TO THIS PROVIDER AND ALSO AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE ABOVE NAMED MEDIGAP INSURER ANY INFORMATION NEEDED TO DETERMINE BENEFITS PAYABLE FOR SERVICES FROM THIS PROVIDER.

SIGN _____ **DATE** _____

MEDICAL HISTORY

Reason for visit: _____

_____

Do you smoke? Yes | No Do you drink alcohol? Yes | No Do you use illicit drugs? Yes | No

If yes, how often? _____ If yes, how often? _____ If yes, how often? _____

Please list any known allergies: _____

(For women) Are you currently pregnant or do you think you might be pregnant? Yes | No

Have you recently noted any of the following (please check all that apply)?

□ fatigue	□ falls	□ heartburn/indigestion	□ shortness of breath
□ fever/chills/sweats	□ numbness/tingling	□ difficulty swallowing	□ fainting
□ nausea/vomiting	□ muscle weakness	□ constipation	□ cough
□ weight loss/gain	□ dizzy/lightheaded	□ diarrhea	□ headaches
□ difficulty maintaining balance while walking		□ changes in bowel or bladder function	

Have you ever been diagnosed with any of the following conditions (please check all that apply)?

□ cancer	□ anemia	□ rheumatoid arthritis	□ osteoporosis
□ heart problems	□ AIDS/HIV	□ bone or joint infection	□ multiple sclerosis
□ chest pain/angina	□ chemical dependency	□ kidney problems	□ epilepsy
□ high blood pressure	□ depression	□ urinary tract infection	□ eye problems
□ circulation problems	□ lung problems/asthma	□ bladder infection	□ ulcers
□ blood clots	□ tuberculosis	□ thyroid problems	□ liver problems
□ stroke	□ osteoarthritis	□ diabetes	□ hepatitis
□ pneumonia	□ pelvic inflammatory disease		

Please list any other known medical conditions: _____

During the past month, have you felt down, depressed, or hopeless? Yes | No
During the past month, have you been bothered by having little interest or pleasure in doing things? Yes | No
Is this something with which you would like help? Yes | Yes, but not today | No

Current medications:

_____

_____

_____

_____

_____

Recent surgeries (please include dates):

_____

_____

_____

_____

_____

Patient's signature: _____ Date: _____

Therapist's signature: _____ Date: _____