Ringwood Physical Therapy

Kevin N. Kopack, MSPT, DPT, OCS
NJ License#40QA00335300

Jeffrey M. Kopack, BS, DPT
NJ License#40QA01573400

NEW PATIENT INFORMATION

Today's Date: _____

Full Name: _____ Date of Birth: _____

Email Address: _____ Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ Employer: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

PRIMARY INSURANCE

Company: _____ ID#: _____ Group#: _____

Insured's Name: _____ Insured's DOB: _____

SECONDARY INSURANCE (IF APPLICABLE)

Company: _____ ID#: _____ Group#: _____

Insured's Name: _____ Insured's DOB: _____

Referring Physician's Name: _____ NPI: _____

Address: _____ City: _____ State: _____ Zip: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: _____

How did you find out about us? (Please circle)

Doctor Referred Me Friend Patient Sign Internet/Web

Other: _____

If referred by a friend/patient, please advise us of whom:

_____

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20 Greenwood Lake Tpke.
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Is your current injury the result of a motor vehicle accident? Yes No

Insurance Co. Name: _____

Policy #: _____ Date of Accident: _____ State: _____

Is your current injury related to Worker's Compensation? Yes No

Employer: _____ Insurance Co. Name: _____

Claim Number: _____ Date of Injury: _____

Adjuster's Name: _____ Adjuster's Phone Number: _____

Is your current injury the result of a fall? Yes No

How many falls have you experienced in the past year? _____

Is there a lawsuit pending related to your current injury? Yes No

If yes, please provide the name of your attorney: _____

Attorney's Email: _____ Attorney's Phone Number: _____

_____ _____ _____

Patient or Guardian's Signature Relationship Date

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MEDICAL HISTORY

Age: _____ Current Height: ____ft _____in Current weight: _____

*Please indicate if you have a personal history of any of the following

High or Low Blood pressure	Yes	No	Fractures	Yes	No
High Cholesterol	Yes	No	Autoimmune Disorder	Yes	No
Diabetes	Yes	No	HIV/AIDS	Yes	No
Cancer	Yes	No	Kidney Problems	Yes	No
Rheumatoid Arthritis	Yes	No	Gallbladder problems	Yes	No
Cardiac Conditions	Yes	No	Thyroid disease	Yes	No
Cardiac Pacemaker	Yes	No	Metal Implants	Yes	No
Emphysema/Bronchitis	Yes	No	Incontinence	Yes	No
Multiple Sclerosis	Yes	No	Allergies	Yes	No
Muscular Disease	Yes	No	Chemical dependency	Yes	No
Osteoporosis	Yes	No	Seizures/Epilepsy	Yes	No
Parkinson's Disease	Yes	No	Dizziness	Yes	No
Hepatitis	Yes	No	Anxiety	Yes	No
Stroke	Yes	No	Depression	Yes	No
Tuberculosis	Yes	No	Smoking	Yes	No
Anemia	Yes	No	Headaches	Yes	No
Asthma	Yes	No	Speech problems	Yes	No
Circulation Problems	Yes	No	Hearing Impairments	Yes	No
Fibromyalgia	Yes	No	Vision Impairments	Yes	No

Other Medical Conditions not listed: _____

Have you undergone any of the following testing? (Please provide dates)

X-ray: _____ MRI: _____ EMG: _____ Cardiac Stress: _____

Bone Density Scan: _____ Other: _____

If you are a female, are you currently pregnant or planning on becoming pregnant? Yes No

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MEDICAL HISTORY

Are you currently taking any medications? Yes No

If yes, please list all medications with dosages below.

Medicare patients are required to list all medications with dosages

Medication	Dosage

Have you undergone any surgeries? Yes No

If yes, please list all surgeries with dates

Surgical Procedure	Date

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Please describe your current condition and when it started: _____

_____

What treatment have you received for your current condition? _____

_____

Are your symptoms (please circle): Improving Staying the same Getting worse

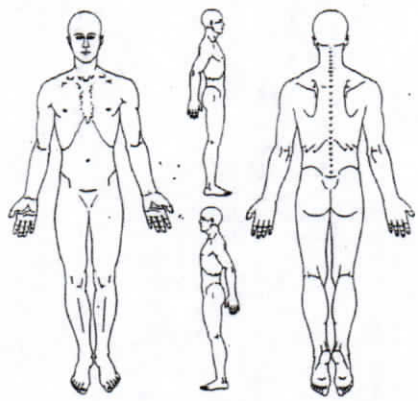
Please describe your recreational activities: _____

_____

Are your work duties (please circle): Light Moderate Heavy

Please describe your work-related activities: _____

_____



Please mark the areas where you feel symptoms on the chart to the left using the following symbols to describe your symptoms:

→ Shooting/ Sharp pain
O Dull/aching pain
= Numbness
~ Tingling

Briefly describe your pain symptoms: _____

_____

_____

_____

My symptoms are currently (please circle): Come and go Are Constant Change with activity

Identify positions or activities that make your symptoms worse: _____

_____

Identify positions or activities that make your symptoms better: _____

_____

How are you currently able to sleep at night due to your symptoms? (please circle)

No problem sleeping Difficulty falling asleep Awakened by pain Sleep only with medication

When are your symptoms worst? (Please circle)

Morning Afternoon Evening Night After Exercise

When are your symptoms best? (Please circle)

Morning Afternoon Evening Night After Exercise

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NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers that may be involved in my treatment directly and/or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that my personal health information WILL NOT be shared with any other parties without my written consent. I have read and understand the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice from time to time and that I may contact them at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may also request in writing that you restrict how my personal health information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that request to forward my medical records to another treating physician other than my referring physician must be made in writing.

Patient name (please print): _____ Date: _____

Patient Signature: _____

Guardian Name (if patient is under 18 years old): _____

Guardian Signature: _____ Date: _____

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CONSENT AND AUTHORIZATION

Please review and initial the following

Consent to Treatment: I hereby consent to physical therapy and related services at Kopack Physical Therapy & Sports Medicine. I understand and acknowledge that such physical therapy and related services may involve direct bodily contact. _____ (initial)

Authorization of Payment: I hereby assign all benefits directly to Kopack Physical Therapy & Sports Medicine and authorize the release of any medical records necessary to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. _____ (initial)

HIPAA Notice of Privacy Practices: I have read and understand the Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices. _____ (initial)

Communications: I hereby grant Kopack Physical Therapy & Sports Medicine the permission to leave a message regarding my current health status and treatment program on my answering machine/ voicemail. _____ (initial)

I hereby grant Kopack Physical Therapy & Sports Medicine permission to discuss my medical condition with: Name _____ Relationship to Patient: _____

_____ _____ _____

Patient or Guardian's Signature | Relationship | Date

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FINANCIAL POLICY

We are committed to providing you with the best possible care. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Please review and initial the following billing procedures that are followed by our practice.

- It is your responsibility to understand your insurance coverage, policy provisions, exclusions/limitations, and authorization requirements. This information is furnished by your insurance carrier. We will contact your insurance company to verify your benefits but they are not always accurate. (initial) _____
- You are responsible for informing us of any changes in your insurance plan or policy. Failure to do so may result in denial or coverage, the fees for which you will be held responsible. We attempt to verify that your coverage is valid at the time of your visit. However, if your coverage is not in effect at the time of your visit, the financial responsibility for payment is yours. (initial) _____
- Pursuant to federal and state law, as well as our contract with insurance carriers, our practice is required to collect all patient responsibility payments (patient responsibility payments include copayments, coinsurances, deductibles and non-covered services). These will be collected at each visit. PLEASE DO NOT ASK US TO "CUT DEALS" OR "WRITE OFF" YOUR PAYMENT RESPONSIBILITIES. (initial) _____
- If your insurance requires a referral, it is your responsibility to request your primary care doctor to issue one. If you arrive for your appointment without a referral, you will not be able to see your therapist. (initial) _____
- If you receive a bill from our practice, please forward payment upon receipt. If insurance payments are sent to you, you are responsible for forwarding payments to our office along with the corresponding EOB (Explanation of Benefits). (initial) _____

We emphasize that as a medical care provider, our relationship is with you and not your insurance company. If you have any questions regarding our financial policy, please do not hesitate to ask.

I have read and understand the financial policy above and agree to the terms. I authorize and guarantee payment for all services rendered. In the event that my account becomes delinquent I understand my account will be forwarded to a collection agency and agree to pay the additional costs, and attorney fees accrued with the collection of this account.

_____ _____ _____

Patient or Guardian Signature | Relationship | Date

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PLEASE BE ADVISED THAT COPAYMENTS ARE DUE AT TIME OF TREATMENT

Patient: _____

Copay Amount: _____

Insurance Company: _____

Some insurance companies allow a limited number of visits for physical therapy. If your treatments are denied, maximum amount is reached, or if you do not have any insurance coverage; you may continue uninterrupted treatments for a **cash payment of $55.00**

Patient Signature: _____

Kopack PT Representative: _____

Date: _____

Revised 3/2019 by N. Mullery, SPT University of Scranton

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