ACTIVECARE
PHYSICAL THERAPY

Compassion, Commitment, Recovery

Welcome to ActiveCare Physical Therapy

Dear Patient;

I would like to take the time to personally thank you for choosing us as your healthcare provider. I hope we can help you in your journey towards improved health.

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well being and gain of your physical abilities is something we at ActiveCare Physical Therapy take very seriously.

Please check in with the front desk at each visit to sign in, pay any copayments or outstanding balances, schedule appointments and confirm your account is up to date. The time we set aside for you and your therapist is valuable, we request all cancellations or reschedules be made with a 24 hour notice. We understand under certain circumstances appointments have to be cancelled last minute, however, if there is a pattern of missed appointments there will be a $50 cancellation fee charge.

My foremost goal is patient satisfaction. Enclosed you will find a copy of our "Patient Satisfaction Survey." I would greatly appreciate it if after your 4th visit you would please take a moment to fill it out and return it to me. This is the best way I know to find out what my office and I are doing right, and what skills we need to improve on. You do not need to put your name on it, so you can feel free to be honest. Thanks!

Feel free to ask me any questions regarding your treatment or progress, and let me know if there is a better way we can assist you.

Sincerely,

Rik Couwenberg
Owner/ Managing Director

Patient Signature:_____Date:_____

Witness:_____Date:_____

ActiveCare
Patient Information Form

Patient Information

Last Name _____ First Name _____ MI ____ SSN _____

Address _____

Address2 _____ City _____ State ____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ Gender ____ Marital Status _____ Email _____

Emergency Contact

Last Name _____ Relationship _____

First Name _____ Phone _____

Employer

Name _____ Phone _____

Address _____

Address2 _____ City _____ State ____ Zip _____

Problem

Problem Description _____ Date of Injury _____ Last Physician Visit / /

Referred By _____

Latest Referral Information _____ Motor Vehicle Accident ____

Latest Plan of Care _____ That occurred in: ____

Notes: _____

Primary Insurance

Insurance _____ Deductible _____

ID _____ Max Benefit _____

Group # _____ CoPay _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

Date of Birth _____

Secondary Insurance

Insurance _____ Deductible _____

ID _____ Max Benefit _____

Group # _____ CoPay _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

Date of Birth _____

Tertiary Insurance

Insurance _____ Deductible _____

ID _____ Max Benefit _____

Group # _____ CoPay _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

Date of Birth _____

I authorize release of information requested by my insurance plan for payment.
I understand that I am financially responsible for any balance due.
I agree to comply with the terms and conditions as outlined on the Patient Registration form.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

(You have the right to refuse to sign this acknowledgement if you so choose.)

Signature:_____ Date:_____

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Medical History Form

Patient Name:_____ Date:_____

Please complete this form to the best of your knowledge, Do you have/Have had:

1. High Blood Pressure yes no
2. Chest Pains/Angina/ Heart Attack yes no
3. High Cholesterol yes no
4. Pacemaker yes no
5. Shortness of Breath yes no
6. History of smoking yes no
7. Lung Problems yes no
8. Emphysema/Asthma yes no
9. Bleeding/Bruising yes no
10. Anemia yes no
11. Diabetes yes no
12. Hypoglycemia yes no
13. Lightheadedness yes no
14. Blood Disorders yes no
15. Concussion yes no
16. Fainting Disorders yes no
17. Anxiety/Panic Attack yes no
18. Arthritis/Joint Pain yes no
19. Artificial Joints yes no
20. Kidney Disease/ Stone yes no
21. Hepatitis yes no
22. Spinal Cord Injury yes no
23. Traumatic Brain Injury yes no
24. Fractures yes no
25. Thyroid Problem yes no
26. Polio/Muscle Disease yes no
27. Seizures yes no
28. Chronic/Migraine Headaches yes no
29. TMJ Disorders yes no
30. Chills/Fevers Sweats yes no
31. Swelling of Extremities yes no
32. Sleep Disorder yes no
33. Depression yes no
34. Fibromyalgia yes no
35. Chronic Fatigue Syndrome yes no
36. Lyme's Disease yes no
37. Cancer/Tumors/Growths yes no
38. Are you Pregnant? yes no
39. Gynecological Disorders yes no
40. Bladder Incontinence yes no
41. Bowel Incontinence yes no
42. Diarrhea/Nausea/Vomiting yes no
43. Unexplained Weight Loss >10 lbs./last30days yes no
44. UNDER 18 ONLY: Immunizations Current yes no
45. Recent falls in the last 6 mths yes no

46.Rate your Pain 0-10 | | | | | | | | | | |
(None) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

Current Medications and dosage:_____

Allergies:

- To Medications:_____
- To Other Substances:_____

Surgery (s) Include Dates:_____

Patient Signature_____ Date:_____

Relationship if other than patient/Parent/ Guardian if Minor_____

This information will be used as a guide in your treatment plan. If you need any medical follow –up please contact your physician

Name:_____

Motor Vehicle Accident Injuries

If you are receiving care for injuries from a Motor Vehicle Accident, what state did the accident occur in?

_____

Patient or Guardian Agreement:

☐ I authorize release of information requested by my insurance plan for payment.
☐ I understand that I am responsible for any balance due.
☐ I agree to comply with the terms and conditions as outlined in the Patient Registration form.

Signature of Patient or Guardian: _____ Date ____/____/_____

Notice of Privacy Practices:

☐ I hereby acknowledge that I have have been offered a copy of the Notice of Privacy Practices. (You have the right to refuse to sign this acknowledgement if you so choose.)

Signature of Patient or Guardian: _____ Date ____/____/_____

Notice of Collection Policy:

☐ I understand that I am financially responsible for all charges whether or not they are paid by insurance. If my delinquent account is sent to a collection agency I agree to the additional of a collection fee of $50 or 25% of the balance owed, whichever is greater. ActiveCare does not accept responsibility for collecting on or negotiating the settlement of any legally disputed claims.

Signature of Patient or Guardian: _____ Date ____/____/_____

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Dear Patients;

In addition to providing your care with highly qualified, licensed physical therapist, we are also a teaching clinic. There may be times when one of the doctoral interns may be providing the treatment under direct or indirect supervision of our physical therapist (s). The therapist will always be in the clinic in case a situation arises. This allows our current licensed therapists to keep up to date with the latest research and treatment protocols, and provides our expertise to future generations of physical therapists.

We appreciate your assistance in promoting the growth of physical therapy services provided at our facility. In order to offer you the highest quality of care: please sign below to acknowledge that you are aware of this policy letter.

If this is a concern or you wish not to be treated by an intern, please let your therapist know beforehand. Your satisfaction with our physical therapy services is our first priority.

Signature:_____Date:_____

Activecare Physical Therapy

Notice of Privacy Practices

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

Use and Disclosures

Treatment- Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, physical therapy evaluations and reports will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment- Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operation- Your health information may be used as necessary to support the day-to-day activities and management of Activecare Physical Therapy. For example information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promoted quality.

Law Enforcement- Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to state's public health departments.

Public Health Reporting- Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorization a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you noticed us of your decision to revoke your authorization.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice

Activecare Physical Therapy LLC Duties

We are required by law to maintain the privacy of your health information and to provide you with this notice of privacy practices.

We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state law and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Request to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, a written request is necessary in order to inspect or copy protected health information. You may obtain a request form to access your records by contacting the receptionist or business operations directory. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concern(s) to:

Activecare Physical Therapy LLC
Att: Office Manager
600 Mt. Pleasant Ave
Suite F
Dover, NJ 07801
Phone: (973) 891-1080
Fax: (973) 891-1081

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filling a complaint.

Signature:_____

Print Name:_____

Date:_____

Would you like a copy: Yes _____ No_____