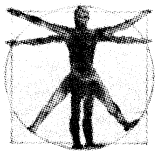

MultiCare Therapy Center
1527 Route 27, Suite 1100
Somerset, NJ 08873
732-545-7474 fax 732-545-2880

Dear Patient,

Welcome to our practice. Thank you for your confidence and trust in scheduling an appointment with our clinic. We are always dedicated to quality care for all our patients and we are always here to discuss your problems and find together the most appropriate solution. Our office patient policies are as follows. Please read carefully the following policies and sign below.

GENERAL OFFICE POLICIES

1) We require 24 hours notice in the event of cancellation. It is your responsibility, when you call in ***to have an alternative time in mind that will ensure you get in the full prescribed number of treatments that week whenever possible.***
2) There is a **$25.00** charge for a no show or cancellation without proper notice. This charge will probably not be covered by your insurance company, but will have to be paid by you personally.
3) You should understand that when you no-show, three people get hurt: 1) yourself because you don't get the treatment you need as prescribed by the doctor and our staff, 2) the therapist who now has a 'vacancy" in their schedule since the time was reserved for you personally, and 3) another patient who could have been given treatment if you had given us proper notice.
4) **Regarding Lateness**: If you are late, you may not get you in your full treatment because it would mean other patients are delayed.
5) **Regarding Being Early**: We will do our best to getyou in as soon as possible. Most of the time you'll have to wait until your scheduled time to be seen because there are other patients who are still in treatment.
6) For your health's benefit we have developed both a formal evaluation process and a discharge process. In each of these, the Physical Therapist prepares a report for your doctor.
7) Please understand that your insurance policy is a contract between you and your insurance company. While we may accept your insurance as payment, your contract with us is a separate agreement. In other words, if your insurance refuses to cover a certain treatment or otherwise fails to pay us, your contract with us still exists, and you are responsible for payment personally.
8) ***Co-pays, deductibles, and payments*** if you are a self-pay patient, payments are due at the time of service. We accept payments by credit card, cash, check, or money orders.
9) We will allow, on special occasions, a long term payment plan budgeted on the individual according to need. In any event, if you request such a plan, you will sign a written agreement which must be given final approval by the Clinical Director.
10) If at any point you have a problem regarding billing and payment, talk to our secretary and they will arrange for you to see our office manager.

After you have read carefully the above, please sign the following:

I _____ **(Please Print)**, agreed to be treated in this Physical Therapy clinic by the Physical Therapist and their staff and I also agree with the terms specified above

X _____ _____

Signature of Patient or Responsible Party Date

Patient Registration

Welcome to MultiCare Therapy Center. In order to serve you properly, we will need the following information.
(Please Print) All information will be strictly confidential.

Patient's Name:_____ Sex: [ ] M [ ] F Date of Birth:_____
(First) **(Last)**

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address:_____ Cell Provider: [ ] AT&T [ ] T-Mobile [ ] Verizon [ ] Other _____

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed Patient's Social Security #:_____

Home Address:_____ City_____ State:_____ Zip code:_____

Person to contact in case of Emergency:_____

Relationship to Patient: _____ Emergency Contact Phone #: _____

Primary Insurance:_____ ID Number: _____

Policy Holder's Name:_____ Policy Holder Relationship to Patient: [ ] self [ ] spouse [ ] other: _____

Policy Holder's Birthdate:_____ Policy Holder's Employer: _____ Employer Phone#:_____

Secondary Insurance:_____ ID Number: _____

Policy Holder's Name:_____ Policy Holder Relationship to Patient: [ ] self [ ] spouse [ ] other: _____

Policy Holder's Birthdate:_____ Policy Holder's Employer: _____ Employer Phone#:_____

Did you sustain an injury at work? **Yes or No** If **YES**, please indicate Date of Injury: _____

Name of Workers Comp?_____ Case #: _____

Currently employed? **Yes or No** Name of Employer: _____ Employer Phone#:_____

Are your injuries related to a Motor Vehicle Accident? **Yes or No** If **YES**, please indicate Date of Accident: _____

Were you the **[ ] Driver** or **[ ] Passenger** during the motor vehicle accident?

Name of Insurance Company?_____ Case #: _____

Are you covered under any other Health Insurance care plan? **Yes or No** Please List:_____

I guarantee that the information I have provided here is true and accurate. I hereby authorize benefits payment directly to MultiCare Therapy Center and acknowledge that I am financially responsible for any unpaid balance.

X _____ _____

Signature of Patient or Responsible Party Date

MultiCare Therapy Center
PATIENT MEDICAL HISTORY FORM

Patient Name: _____

1.Have you ever suffered from?

	YES	NO
Allergies	___	___
Anemia	___	___
Asthma	___	___
Balance Problems	___	___
Blood Disease	___	___
Bruise Easily	___	___
Cancer	___	___
Cardiac Problems	___	___
Circulatory Problems	___	___
COPD	___	___
Diabetes	___	___
Emphysema	___	___
Hearing Problems	___	___
Heart Attack	___	___
Heart Disease	___	___
High Blood Pressure	___	___
HIV	___	___
Jaundice/Hepatitis	___	___
Kidney Disease	___	___
Low Blood Pressure	___	___
Pacemaker	___	___
Seizures	___	___
Vision Problems	___	___

2. Have you had physical therapy in the last 12 months? If so, how many visits were completed?

_____

_____

_____

_____

3. In a few words, describe the reason for todays visit.

_____

_____

_____

_____

4. What goals would you like to meet? And why is this important?

_____

_____

_____

_____

5. What medications are you currently taking? Please List medications or attach medications list.

❒ Currently Not Taking Medication

_____

_____

6. What medications are you allergic to? _____

_____

7. What is your primary physician's name and when was your last physical examination?

Name of Physician: _____

Address: _____

_____

8. Have you had a recent:

	Normal	Abnormal	Yes	No
Chest X-Ray			__	__
Electrocardiogram			__	__

9. Have you ever had any previous surgery?

What Kind/When/Where? _____

_____

_____

10. Do you have any metal implants or pacemaker? (what/where)

_____

11. Do you have any disease or medical problem not listed you feel that we should know about?

_____

_____

12 **a**. Did you receive any treatment/procedure at the hosptial/ER?

_____

12 **b**. Were you taken to ER by an ambulance?

☐ **YES** ☐ **NO**

13. Do you have any of the following habits?

	Yes	No
Smoking	___	___
Alcohol	___	___
Recreational Drugs	___	___

x _____ _____

Signature of Patient or Responsible Party Date

MultiCare Therapy Center
1527 Route 27, Suite 1100
Somerset, NJ 08873
732-545-7474 fax 732-545-2880

Consent to Treat/Release of Information

CONSENT TO EVALUATE AND TREAT
I do hereby consent to the evaluation and treatment by MultiCare Therapy Center. I understand that it is my right to accept or refuse any treatment offered to me. I acknowledge and understand that no guarantee has been made to me as to the results that may be obtained from such treatment.

RELEASE OF INFORMATION
I authorize MultiCare Therapy Center to release information from my medical record, whether it be written, video, photographic, audio or verbal to my physician and/or any third party payor (such as insurance company, governmental agency, or attorney) for its use in processing claims for payment. I understand the nature of the authorization and have been informed that I have the right to revoke consent at any time by written communication with custodians of records.
I consent to the release of medical information to:

_____

_____
for communication and care coordination on my behalf.

Was also offered a copy of the Procedure for filing a grievance and Patient Rights.

X_____ _____
Signature of Patient or Responsible Party Date

ASSIGNMENT OF BENEFITS
I request that payment of Medicare and/or other insurance benefits be made on my behalf to MultiCare Therapy Center for any services furnished to by MultiCare Therapy Center.

FINANCIAL AGREEMENT
The undersigned agrees, whether signing as agent or patient, that s/he individually obligates her/himself to pay for services rendered in accordance with the regular rates and terms of MultiCare Therapy Center. MultiCare will verify insurance benefits on behalf of the patient. Verification is no guarantee of payment. The agent/patient is responsible for any co-payment, deductible, co-insurance and all amounts indentified by the insurer as the patient's responsibility. A fee of 33% will be added to the outstanding balance if the outstanding balance will be referred to collection. This information will be used for the purpose of evaluating and administering claims of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

INSURANCE COVERAGE
I understand that if I fail to disclose any effective insurance coverage at the time of this signing or after the first service date when said insurance became effective, I can be held responsible for any balances not covered by said insurance. This includes balances due to lack of authorization.

I authorize MultiCare Therapy Center to leave messages regarding appointments on my home answering machine. **YES** **NO**

I authorize MultiCare Therapy Center to leave messages regarding appointments with member of my household. **YES** **NO**

The undersigned certifies that s/he has read, understood and accepts the terms of this form, and is the patient or is duly authorized by the patient as the patient's general agent to execute this form.

X_____ X_____ _____
Patient or Responsible Party **(PLEASE PRINT)** Signature of Patient or Responsible Party Date

MultiCare Therapy Center
1527 Route 27, Suite 1100
Somerset, NJ 08873
732-545-7474 fax 732-545-2880

HIPAA
Notice of Privacy Practice

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

Protected Information: While receiving care from our facility, information regarding your medical history, treatment, and payment for your health care may be originated and/or received by us. Information which can be used to identify you and which relates to your past, present, or future medical condition, receipt of health care or payment for health care ("Protected Information").

Our Responsibilities: Federal law imposes certain obligations and duties upon us as covered health care provider with respect to your Protected information. Specifically, we are required to:

- Provide you with notice to our legal duties and our facility's policies regarding the use and disclosure of your Protected Information;
- Maintain the confidentially of your Protected Information in accordance with state and federal law;
- Honor your requested restrictions regarding the use and disclosure of your Protected Information without your authorization, in which case you will be notified within a reasonable period of time;
- Allow you to inspect and copy your Protected Information during our regular business hours;
- Accommodate reasonable requests to communicate Protected Information by alternative means or methods; and
- Abide by terms of this notice.

How your Protected Information Can Be Used and Disclosed: Generally, your Protected Information may be used and disclosed by us only with your express written authorization. However, there are some exceptions to this general rule.

Treatment, Payment, Collections, or Health Care Operation: Treatment/Collection Purposes. We may disclose your Protected Information for various treatment purposes and for the collection of past due amounts. During your care at our facility, it may be necessary for various personnel involved in your case to have access to Protected Information in order to provide you with quality care. In addition, we may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services which may be of interest to you.

Acknowledgement of Receipt of HIPAA Privacy Practice Notice

By signing below, you are acknowledging that you have received a copy of MultiCare Therapy Center's Notice of Privacy Practices.

X _____ X _____ _____

Patient or Responsible Party **(PLEASE PRINT)** Signature of Patient or Responsible Party Date

MultiCare Therapy Center

Advanced Directives/ “Living Will”/DNR Forms/ POLST Forms
Patient Information/ Acknowledgement

Please be advised that MultiCare Therapy Center has an emergency policy and procedure which indicates that 911 will be called for all patient emergencies. We request that all patients, upon admission, supply MultiCare Therapy Center with copies of their Advanced Directives to retain in their medical chart so that in the event of a 911 emergency we can give your directives to the Emergency Transit Team.

Do you have an Advanced Directive/ “Living Will” / DNR instructions?	_____ yes	_____ no
Copies provided to MultiCare Therapy Center?	_____ yes	_____ no
Have you filled out POLST (Practioner Orders for Life Sustaining Treatment) forms?	_____ yes	_____ no
Copies of completed POLST forms provided to MultiCare Therapy Center?	_____ yes	_____ no

_____ _____

Patient Signature Date

NOTICE OF FACILITY'S LIEN

Patient Name: _____ Date of Accident: _____

I do hereby authorized NKR, LLC, d.b.a. MultiCare Therapy Center to furnish you, my Attorney, with a full report of its examination, diagnosis, treatment, prognosis, etc. of myself in regard to the accident in which I was recently involved.

I hereby authorize and assign you, my Attorney, to pay directly to said facility such sums as may be due and owing it for medical and therapy service rendered me by reason of this accident, and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protected and fully compensate said facility. I hereby further give a Lien on my case to said facility against any and all proceeds of my settlement, judgement, or verdict which may be paid to you, my Attorney, or me, as the result of the injuries in connection therewith.

I fully understand that I am directly and fully responsible to said facility for all medical bills submitted by it for service rendered me and that this agreement is made solely for said facility's additional protection and in consideration of its awaiting payment. I further understand that such payment is not contingent on a settlement, judgement, or verdict by which I may eventually recover said fee.

I agree to promptly notify said facility of any change or addition of Attorney (s) used by me in connection with this accident, and I instruct my Attorney to do the same and to promptly deliver a copy of this Lien to any such substituted or added Attorney(s).

Please acknowledge this letter by signing below and returning to the facility. I authorize my Attorney to sign this form and this authorization form irrevocable.

_____ _____

DATE Patient's Signature

If translated, signature of translator

_____ _____

DATE Patient's Signature

Attorney's Name: _____

Attorney's Address: _____

Amount of Lien: _____

The undersigned being Attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgement, or verdict, as may be necessary to adequately protect and fully compensate said facility above-named.

_____ _____

DATE Attorney's Signature

***PLEASE DATE, SIGN AND RETURN TO FACILTY*:** NKR, LLC, d.b.a. MultiCare Therapy Center
1527 State Route 27, Suite 1100
Somerset, NJ 08873
732-545-7474 FAX 732-545-2880

MultiCare Therapy Center

INTERDISCIPLINARY CARE MEETING

Patient's Name: _____ **Diagnosis**: _____

Date of Review: _____ **SOC**: _____ **Referring Physician**: _____

Disciplines involved: ___ RT ___ PT ___ OT ___ SP ___ SW ___ DT **Patient Present?** ___Y ____N

Discharged Plan: _____

Functional Goals and or Progress since last conference: _____

_____

_____

Precautions: _____

_____

Functional Deficit Remaining: _____

_____

_____

_____

Disc	Problem	Treatment Plan Including Frequency & Duration

Patient's Response to treatment: _____

_____

_____

Additional Referrals Recommended:

_____ Social Services _____ Nutritional Counseling

_____ Community Resources (_____)

_____ Other: _____

Recommendation:

_____ Continue with Plan of Care _____ Revise Plan of Care

_____ Discharge (when: _____)

_____ Other: _____

Signatures and Credential of Team Members:

_____ Patient: _____

_____ Caregiver: _____

_____

MultiCare Therapy Center
1527 Route 27, Suite 1100
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INFORMED CONSENT FOR TREATMENT/PROCEDURE

Physical Therapy in the Era of Covid-19

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "Coronavirus", at any time or in any place. Be assured that we have always followed state and federal regulations and recommend universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so.

Despite our careful attention to sterilization, disinfection, and use of personal protective barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store, or favorite restaurant. "Social Distancing" nationwide has reduced the transmission of the Coronavirus. Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not always possible to maintain social distancing between patient and therapist at all times.

By signing this form, I consent to treatment with a MultiCare Therapy Physical Therapist.

Patient Name: _____

Patient/Gaurdian or patient over 18 years old

Signature: _____ Date:_____