SOUTH ORANGE
Rehabilitation & Wellness

Please complete the following intake paperwork. We rely on its accuracy and completeness to provide you with the best possible care.

Patient Information

Today's Date:_____ Email Address:_____

Your Name:_____ Date of Birth:_____ Age:_____

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

S.S.N:_____ Marital Status:_____ How did you hear about us?_____

Cell Phone #:_____ Home/Work Phone #:_____

Emergency Contact

Name:_____ Relationship:_____

Cell Phone #:_____ Other Phone #:_____

Pain Description and Symptoms

Referring Physician:_____ Office Phone #:_____

Reason for your visit today:_____

Approximately when did this pain begin?_____

How did your current pain begin? ☐ Gradually ☐ Suddenly ☐ Other:_____

When is your pain at its worst? ☐ Morning ☐ Daytime ☐ Night-time ☐ Other:_____

How often does the pain occur? ☐ Constant ☐ Severity changes but always present ☐ Intermittent

Mark the following physician's or specialists you have consulted for your current condition:

☐ Chiropractor ☐ Neurosurgeon ☐ Physical Therapist ☐ Neurologist ☐ Pain Specialist

☐ Orthopedic Physician ☐ Primary Care Physician ☐ Other:_____

Past Medical History

Mark the following conditions/diseases that you have been treated for in the past:

General Medical

☐ Cancer (Type:_____) ☐ Diabetes (Type:_____)

Head/Ears/Eyes/Nose/Throat

☐ Headaches ☐ Migraines ☐ Head Injury ☐ Hyperthyroidism ☐ Glaucoma

Cardiovascular/Hematologic

☐ Pacemaker/Defibrillator ☐ High Blood Pressure ☐ Irregular Heart Beat ☐ Anemia

☐ Heart Attack ☐ Stroke/TIA ☐ Coronary Artery Disease ☐ Congestive Heart Failure

☐ Blood Clot/Embolism ☐ Heart Valve Disorders ☐ Peripheral Vascular Disease

☐ Infectious Disease (TB, Hepatitis, HIV, etc.)

Respiratory

☐ Asthma ☐ Bronchitis/Pneumonia ☐ Emphysema/COPD ☐ Sleep Apnea

Gastrointestinal

☐ GERD (Acid Reflux) ☐ Gastrointestinal Bleeding ☐ Stomach Ulcers ☐ Constipations

Urological

☐ Chronic Kidney Disease ☐ Kidney Stones ☐ Urinary Incontinence ☐ Dialysis

Neuropsychological

☐ Multiple Sclerosis ☐ Myasthenic gravis ☐ Guillian-Barre ☐ Peripheral Neuropathy

☐ Seizures/Epilepsy ☐ Depression ☐ Anxiety ☐ Parkinsons

Musculoskeletal

☐ Bursitis/Tendonitis ☐ Broken Bones/Fractures ☐ Weakness in arms/legs ☐ Osteoporosis

☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Chronic Joint Pains

Women

☐ Pelvic Inflammatory Disease ☐ Endometriosis

☐ Are you pregnant or think that you might be pregnant? ☐ Yes ☐ No

Other

Other Diagnosed Conditions:_____

Family History

☐ Cancer ☐ High Blood Pressure ☐ Osteoporosis ☐ Stroke ☐ Diabetes

☐ Kidney Problems ☐ Rheumatoid arthritis ☐ I have no significant family medical history

Past Surgical History

Please list any surgical procedures you have had done in the past including the date:

1) _____ Date: _____

2) _____ Date: _____

3) _____ Date: _____

Current Medications

Are you currently taking any blood thinners or anti-coagulants? ☐ Yes ☐ No

If Yes, which ones? ☐ Asprin ☐ Plavix ☐ Coumadin ☐ Lovenox ☐ Other: _____

Please list all the medications you are currently taking, including non-prescription medication:

Medication Name	Dose (if known)
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____

Allergies

Do you have any drug/medication allergies? ☐ Yes ☐ No

If so, please list all medications you are allergic to: _____

Topical Allergies: ☐ Latex ☐ Iodine ☐ Tape ☐ IV Contrast

Social History

Occupation: _____

Employment Status: ☐ Full-time ☐ Part-time ☐ Student ☐ Homemaker ☐ Retired

☐ Homemaker ☐ Temporary Disability ☐ Permanent Disability ☐ Unemployed

Are you currently under worker's compensation? ☐ Yes ☐ No

Is there an ongoing lawsuit related to your visit today? ☐ Yes ☐ No

Who is in your current household? _____

Are there any stairs in your current home? ☐ Yes ☐ No If so, how many? _____

Alcohol Use

☐ Social Use ☐ History of Alcoholism ☐ Current Alcoholism ☐ Daily Use ☐ Never

Tobacco Use

☐ Current User ☐ Former User Packs per day:____ How many years? _____ Quit Date:_____

☐ Never Used

Do you have a history of chemical dependency? ☐ Yes ☐ No

Patient Signature:_____

Electronic Use Policy

In order to ensure that all patients have an enjoyable physical therapy experience, we have implemented a no cell-phone usage policy. By signing below, you agree to the following:

1) Upon entering the facility, phones will be silenced or put on vibrate.
2) There will be no music, videos, audio or phone conversations permitted to be played aloud when inside the facility.
3) If you would like to listen to music, videos, or audio in the facility, you may do so only when using headphones.
4) No phone calls/conversations are permitted inside of the facility. Please be courteous and take all phone calls outside.

Patient Signature:_____

SOUTH ORANGE REHABILITATION & WELLNESS AGREEMENT

CONSENT FOR MEDICAL TREATMENT

I hereby authorize South Orange Rehabilitation & Wellness to administer and perform procedures deemed necessary or advisable in the treatment plan of the patient.

Patient Initials:_____

CONFIDENTIALITY

Patient privacy and confidentiality is important to us. Due to the nature of our facility (open gym area), conversations may be overheard by other patients. As a result of this, some information may be shared. If you have anything that you would like to discuss with the therapist in private, please be sure to bring it to the therapist's attention. If you have any other concerns about confidentiality and/or privacy, please feel free to let us know.

In addition, a reminder for appointments is a service that we provide. Many patients appreciate this service; however, under new HIPPA regulations, we understand that leaving specific information regarding your personal health may be a violation of your privacy. Please indicate your preferences by checking off one of the boxes below:

☐ Yes, I authorize voicemails to be left at the phone numbers listed in this packet.

☐ No, I do not authorize voicemails to be left.

Patient Initials:_____

AGREEMENT FOR FINANCIAL RESPONSIBILITY:

I hereby authorize payment directly to South Orange Rehabilitation & Wellness by my insurance carrier, of benefits otherwise payable to me. Such payment not to exceed regular charges for the services performed. I understand that I am financially responsible to South Orange Rehabilitation & Wellness / South Orange Chiropractic Center for the charges not paid under this agreement.

Furthermore, I understand that if my failure to make the above payment results in my file being sent to collections, I will pay an additional 33.3% of the outstanding balance as reimbursement to the facility for legal fees. This will be in addition to any court costs and constable fees that are allowed by the court. I also understand that if I am inadvertently overcharged, I will receive a refund immediately.

Patient Initials:_____

Patient Signature:_____

HEAD TO TOE PHYSICAL THERAPY

SOUTH ORANGE REHABILITATION & WELLNESS

Appointment Cancellation, No Shows, & Late Arrival Policies

We strive to provide excellent care to you and to all of our patients. Consistent with this, we have developed appointment cancellation and no-show policies that allow us to better schedule appointments for all patients. When an appointment is scheduled, that time has been specifically reserved for you and when it is missed, that time cannot be used to treat another patient in need of care. We sincerely appreciate your assistance and cooperation in this matter.

Our Cancellation & No-Show Policy is as follows:

We request that you please give our office **at least 24-hour notice** in the event that you need to reschedule your appointment. If you do not provide us with a 24-hour notice or if you do not show up for a scheduled appointment, you will be charged a **$50** non-refundable fee for each time you do not show.

A patient who is a no-show three times or more will be removed from any future appointments and will be required to call the day of to be seen.

Our Late Policy is as follows:

If a patient is more than 15 minutes late to their appointment, the appointment may be canceled and need to be rescheduled. Please give us a call if you are running late.

If you have any questions regarding these policies, please let our staff know and we will be glad to speak with you in more detail.

I have read and understand South Orange Rehabilitation & Wellness' *Appointment Cancellation, No Shows, & Late Arrival Policies.*

_____

Patient Signature *Date*

I _____ **(print name) have read and received a copy of South Orange Rehabilitation & Wellness' *Appointment Cancellation, No Shows, & Late Arrival Policies.***

SOUTHORANGEREHAB.COM
177 VALLEY STREET
SOUTH ORANGE, NJ 07079
T-973-761-0077
F-973-761-0024

HEAD TO TOE PHYSICAL THERAPY

SOUTH ORANGE REHABILITATION & WELLNESS

ASSIGNMENT OF CLAIM BENEFITS

TO: _____

ADDRESS: _____

_____

_____

CLAIM #: _____

POLICY #: _____

DOA: _____

Payment benefits due to me out of indemnity under the terms of an insurance policy issued by your company are hereby assigned to South Orange Rehabilitation & Wellness.

Payment is assigned upon receipt of bill for services rendered by South Orange Rehabilitation & Wellness. Payment of the amount as herein directed, in whole or part, shall be considered the same as if paid by your company directly to me.

By signing this document, I am authorizing South Orange Rehabilitation & Wellness to begin litigation on my behalf, if necessary, against you.

It is agreed that nothing herein relieves me of the primary responsibility and obligation of paying South Orange Rehabilitation & Wellness.

_____ Date

_____ Patient Name

_____ Witness

_____ Patient Signature

I also authorize and direct my attorney to pay the outstanding balance of any bill due to South Orange Rehabilitation & Wellness out of the proceeds of any judgment, settlement of award recovered by me if at the time of such judgment, settlement of award, the amount due to South Orange Rehabilitation & Wellness has not been paid from any other source, notwithstanding that a lawsuit may be pending against my insurance company pursuant to this assignment to collect benefits that have been assigned.

_____ Date

_____ Patient Name

_____ Witness

_____ Patient Signature

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