• 788 Morris Turnpike • Short Hills • New Jersey • 07078 • Tel (973)467-4444 • Fax (973) 467-4446 •

CONFIDENTIAL PATIENT DATA

Name: _____ Date of Birth: _____

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

Home #: _____ Work #: _____ Cell #: _____

E-Mail: _____

Occupation: _____ Employer: _____

Insurance Company: _____ ID #: _____

Secondary Insurance Company: _____ ID #: _____

Emergency Contact: _____ Phone #: _____

Relationship: _____

Is this injury work related? YES NO
Is this injury due to an automobile accident? YES NO
If yes, what was the date of the accident? _____

Auto Insurance Company: _____
Claim Number: _____ Date of Accident: _____
Name of Adjuster: _____ Adjuster Phone #: _____

Premier PT, LLC accepts auto claims under the following conditions:

1. Medical benefits for the patient's Auto Insurance are accepted; however, in addition, the patient must have: a. Private health insurance that will be billed for treatment in the event that the medical on their auto policy is exhausted, or b. The patient must pay for treatment at the time of visit with a credit card that will be kept on file for future payments.
2. If the patient is using private health insurance, they are responsible for any copay, coinsurance, and/or deductible dictated by their insurance plan.

I have read the above information and by signing below consent to financial responsibilities, release of information, assignment of benefits, and acknowledgement of privacy practices.

Signature of Patient or Guardian: _____ **Date:** _____

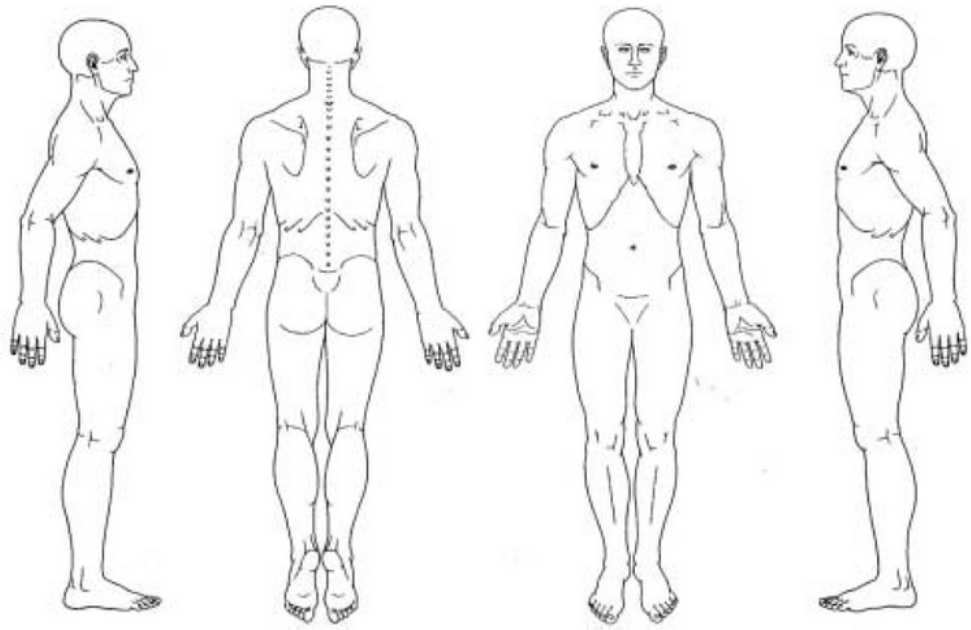
MEDICAL HISTORY

Reason for today's visit: _____

Date of Injury/Onset of Problem: _____was the Onset: ____Sudden ____Gradual

On a scale of 1-10 (10 being worst) how intense is your pain? At Best:_____ At Worst:_____

Please mark an X to indicate the areas where you feel pain, swelling, numbness or discomfort. Describe what you feel or observe in your own words. Write anywhere in this area.



Patient's Initials: _____

General Health Screening Questionnaire

In order for us to provide a thorough evaluation, please answer the following questions regarding your medical history. **Please check any of the following conditions that you may have:**

Cancer _____
Do you have a pacemaker?_____
High Blood Pressure _____
Heart Condition _____
Emphysema or Bronchitis _____
Asthma _____
Circulation/Vascular Problem _____
Diabetes _____
Stroke _____
Low Blood Sugar _____
Osteoarthritis _____
Osteoporosis _____
Thyroid condition _____
Rheumatoid Arthritis _____
Fractured/Broken Bones _____
Other Arthritic Conditions _____
Other Neurological Condition _____
Depression _____
Mental Illness _____
Epilepsy or Seizure _____
Chemical Dependency/Alcoholism _____
Ulcers or Stomach Problems _____
Kidney Disease _____
Anemia _____

Please explain (if necessary) any above checked issues: _____

_____

_____

Do you smoke? Yes No
Do you drink alcohol? Yes No
Are you allergic to Latex? Yes No

Have you had any surgeries? Yes No
If yes, when and what surgeries have you had: _____

_____

_____

Are you taking medications at this time? Yes No
If yes, please list: _____

_____

Patient Signature or Guardian: _____ **Date:** _____

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Acknowledgment of Receipt of Privacy Notice

Purpose of this acknowledgment: This acknowledgement, which allows the practice to use and/or disclose personally identifiable health information for treatment, payment or healthcare operations, is made to the requirements of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996. ("Privacy regulations")

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me to Premier PT LLC (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy regulations.
2. I am aware that the practice maintains a privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the privacy notice.
3. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used to disclose to carry out the treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify if otherwise in writing.

I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions): _____

I understand the foregoing provisions, and I wish to sign the Acknowledgment authorizing the use of my personally identifiable health information for the purposes of treatment, payment and healthcare operations.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT, AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

_____ _____

Signature of patient or representative Date

_____

Patient's Name

_____ _____

Name of personal representative (if applicable) Relationship to patient