AIM orthopedics
Physical Therapy & Sports Medicine

44 Main St
Little Falls, NJ 07424
Tel: 973-860-0550

Patient Information

Appt Date: ____________________ Referring Physician (if applicable): ____________________________

Patient Name: ____________________________________ Sex: Male/ Female DOB: _________________

Address____

Phone#:(______) ________-__________ (Home/Cell) Email Address: _______________________________

Marital Status: Single/ Married/ Widowed/ Divorced **Employed**: Full Time/ Part Time/ Unemployed

Student: Full Time/ Part Time/ Not a Student

Diagnosis____________________________ Surgery? Y N Type________________ Date ____________

Is this injury a: □ Slip & Fall □ Worker's Comp □ Motor Vehicle Accident □ School Injury

Have you retained an attorney due to your injury? □ Yes □ No (if Yes please fill in Attorney information)

How did you hear about AIM Orthopedics? ____

Is there someone we can thank for referring you to our office? _____________________________________

Have you had PT/OT this year? Yes / No If yes, Where? ____

Have you had home health aide/Nurse helping at home? Yes / No How Long? _____________________

Employer (Name):____

Address(City, State, Zip): ____

Phone #:(______) _________ - _________ Ext____________

School (Name):____

Address (City, State, Zip):____

Phone #:(______) _________ - ______________

Emergency Contact (Name): ____

Relationship: ______________________________________ Phone #:(_______) ________ - ____________

Attorney (if applicable): ____

Address(City, State, Zip): ____

Telephone #: (_______) ________-_____________ Case #:____

Patient/Guardian Signature: ____ **Date** :_____________

Print Name: ____

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Notice of Privacy Practices Acknowledgement/Patient Consent:

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health information (PHI) is protected for privacy. The Privacy rule provides standards for health care providers it follows when disclosing patient health information that is needed to carry our proper treatment, payment, or health care operations. As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. When it is necessary, we provide the minimum amount of information to only those we feel are in need of your health care information. We strive to provide the best health care that is in our best interest. We also want you to know that we support your full access to your personal medical records. If you want to request restrictions pertaining to parties you do not want PHI released to please tell our staff and it will be documented in your chart. If you have any further questions about the privacy of your medical records or our general policy please let our staff know. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

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

Please list anyone, other than yourself, that you would like to allow to speak to us regarding your private health information

Name_____________________________ Relationship__________________ Phone________________

Name_____________________________ Relationship__________________ Phone________________

Patient/Guardian Signature: ____________________________________ Date :___________

Print Name: ____

Informed Consent

The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand the risks involved in physical therapy. I hereby consent to evaluation and/or treatment of my condition by licensed physical therapist employed by *AIM Orthopedics, LLC*.

Patient/Guardian Signature: ____________________________________ Date: ___________

Print Name: ____

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ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

AIM Orthopedics, LLC

Financial Responsibility

I have requested professional services from AIM ORTHOPEDICS LLC ("Provider") on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advanced.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to the Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to the Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

____ ____________________

Patient Signature Date

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Medical History Questionnaire

Name_________________________________D.O.B.___________Occupation_________________

Height____________________ Weight_________________

Referring Physician___________________________________ Next MD visit_____________________

Are you taking any prescription or non-prescription medications **for this injury**? (please list)

____

Are you taking any prescription or non-prescription medications **for any other medical conditions**? (please list) ____

FOR THIS CONDITION:

Have you been treated by any of the following?

	Yes	No
Physical Therapy	☐	☐
Neurologist	☐	☐
Orthopedist	☐	☐
Podiatrist	☐	☐
Chiropractor	☐	☐
Occupational Therapy	☐	☐

Have you had any of these exams?

	Yes	No
CT Scan	☐	☐
EMG/NCV	☐	☐
MRI	☐	☐
Myelogram	☐	☐
X-Rays	☐	☐

Do you have or have you ever had ANY of the following?

	Yes	No		Yes	No
Asthma	☐	☐	Vision Difficulty	☐	☐
Bronchitis	☐	☐	Hearing Difficulty	☐	☐
Emphysema	☐	☐	Dizziness or Fainting	☐	☐
Weakness	☐	☐	Weight Loss	☐	☐
Angina	☐	☐	Energy Loss	☐	☐
Coronary Artery Disease	☐	☐	Anemia	☐	☐
High Blood Pressure	☐	☐	Lyme Disease	☐	☐
Heart Attack/Surgery	☐	☐	Epilepsy/Seizures	☐	☐
Pacemaker	☐	☐	Thyroid trouble/Goiter	☐	☐
Stroke/TIA	☐	☐	Blood Clot/Emboli	☐	☐
Headaches	☐	☐	Difficulty Sleeping	☐	☐
Metal Implants/Pins	☐	☐	Bowel/Bladder Problem	☐	☐
Joint Replacement	☐	☐	Neck Injury/Surgery	☐	☐
Diabetes	☐	☐	Shoulder Injury/Surgery	☐	☐
Chronic Fatigue	☐	☐	Elbow/Hand Injury/Surgery	☐	☐
Cancer	☐	☐	Back Injury/ Surgery	☐	☐
Arthritis	☐	☐	Knee Injury/Surgery	☐	☐
Osteoporosis	☐	☐	Ankle/Foot Injury/Surgery	☐	☐
Fibromyalgia	☐	☐	Are you pregnant?	☐	☐
Neurological Problems	☐	☐	Do you smoke?	☐	☐

Please list any injury or illness not listed above

____

Patient Signature____ Date_______________

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RELEASE OF RECORDS

Date: ______________________ RE:_______________________

D.O.B: _____________________

You are hereby requested and authorized to disclose, make available and furnish to ***AIM Orthopedics, LLC*** whose address is:

44 Main Street
Little Falls, NJ 07424

all information, records, hospital records, x-ray's, reports or copies thereof relating to my examination, consultation, confinement or treatment and to permit them to inspect and make copies or abstracts thereof. You are also authorized to send any psychiatric, drug and/or alcoholic information if applicable.

Approximate date of admission to hospital, first examination, treatment or consultation:

____

____

Patient/Guardian Signature Date

AUTHORIZATION FOR APPEALS

Date:___________________________________

Patient Name: _____________________________

DOB:___________________________________

Insurance Co.:____________________________

I authorize AIM Orthopedics, LLC and its billing staff to appeal any claim(s) for service(s) rendered on my behalf as my Designated Representative. As part of the appeal, I hereby authorize the above mentioned Insurance Company, in its decision letter and in connection with the appeal, to communicate with my Designated Representative in all aspects of the appeal.

I understand this information is privileged and confidential and will only be release as required or permitted by law. This authorization will be valid from the date of signature.

____

Signature of Patient or guardian Date