Dr. Monica's Physical Therapy
1401 Valley Rd, Wayne, NJ 07470
Suite200

Email: drmonicanj@gmail.com
Phone: 201-485-3340
Fax: 201-425-7299

Patient Information

Date:____________________

Last Name:__________________________________First Name:_______________________________________

Date of Birth:__________________SSN#(For Insurance Verification Purpose):____________________________

Address:____City:_________________________________

State:_____________Zip Code:________________ Contact #:______________________________________

Email:____Referral Name (If applicable):_____________________

Employer:____Job Title:___________________________________

Employer Address:____

Name of Spouse/ If Child, Parent Name:____

Emergency Contact:_____________________________________Phone#:______________________________

Reason for visit:___________________________________Date Symptoms Began:_____________________

Referring/Prescribing Physician:____

Is this related to an auto accident? Yes:_____No:____If yes, date of accident:____________________

Is this related to workers comp? Yes:________No:____If yes, date of accident:____________________

Patient Information Continued

Primary Health Insurance Company:____________________________________ID:____________________________

Subscriber's Name:________________________________Subscriber's Date of Birth:__________________________

Relationship to Subscriber:_________________________Subscriber's Address & Phone if different from patient.

Address:____

Phone:______________________________

Secondary Health Insurance Company:_________________________________ID:____________________________

Subscriber's Name:________________________________Subscriber's Date of Birth:__________________________

Relationship to Subscriber:_________________________Subscriber's Address & Phone if different from patient.

Address:____

Phone:______________________________

Assignment & Instruction For Direct Payment To Health Provider

I hereby instruct the above named insurance company/companies to pay by check made out to and mailed directly to: Dr. Monica's Physical Therapy for professional/medical expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee and I agree to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment as required by my insurance policy. I understand that Dr. Monica's Physical Therapy is compliant with HIPAA and will protect my Protected Health Information (PHI) and will use it as allowable by law in the treatment, billing and collection pertaining to my care until my case is closed and full payment is received. I also authorize the release of any information pertinent to my case to any insurance, adjuster or attorney for the purpose of securing payment under this insurance policy or to any medical provider associated with my case to effectively treat me, following HIPAA guidelines. The authorization is in effect until 90 days from the date the last bill is collected.

Patient Name:____Signature:________________________________

Parent Name If Patient Under 18 Years of Age:____

Parent Signature:________________________________ Date:____

Witness Signature:______________________________Date:____

Dr. Monica's Physical Therapy LLC
1401 Valley Road, Wayne, NJ 07470
Suite 200

Phone: 201-485-3340
Fax: 201-425-7299

Consent To Treat

I, hereby, authorize Dr. Monica's Physical Therapy LLC and/or all licensed personnel to Perform or have performed upon me, the above named patient, appropriate assessment And treatment procedures.

Signature:____Date:________________________

Signature of Parent if Patient is a minor:____

Parent Name:____Date:________________________

Authorization to Release Healthcare Information

To:____
Doctor / Physician / Attorney / Facility Names

If MVA or Workers' Compensation Case:

Case Manager Name:_____________________________________Phone#:___________________________

Claim #:____Date of Accident:_________________________

I am currently being treated at Dr. Monica's Physical Therapy and authorize the release of any Medical reports including but not limited to: MRI's, Evaluations, Progress Notes, Examination Forms, Etc. to this office.

Signature:____Date:________________________

Signature of Parent if Patient is a minor:____

Parent Name:____Date:________________________

Witness Signature:____