

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 Last First Middle			Sex M F	Birth Date ____/____/____ Age _____	Marital Status Single [] Married [] Widowed [] Divorced []
Residence Address		City	State	Zip	Patient's Social Security #
Home phone	Work phone	Cell or other phone		e-mail address	
Name of employer			Address or ____ Not Applicable		Occupation
Reason for Visit			Referred By: (Include address and phone)		
Person to Contact in Case of Emergency:		Relationship to Patient:		Phone #:	

Primary Insurance	ID Number	Effective Date	Policy Holder Relationship to patient [] self [] spouse [] Other _____		
Policy Holder's Name	Policy Holder's Birthdate ____/____/____		Policy Holder's Employer	Employer Tel #	

Secondary Insurance	ID Number	Effective Date	Policy Holder Relationship to patient [] self [] spouse [] Other _____		
Secondary Insurance Policy Holder's Name		Policy Holder D.O.B.	Policy Holder's Employer	Employer Tel #	

Motor Vehicle Accident? Yes [] No []	Date of Accident	Claim #
Name of Insured (auto owner)	Insurance Company Name	

Workman's Comp? Yes [] No []	Date of Accident	Case/Carrier #	Name of Union, if member
Name of Employer	Employer Tel #	Union Tel #	

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.

 Patient, Parent or Guardian Signature (if child is under 18 years old)

 Date

**MultiCare Therapy Center
PATIENT MEDICAL HISTORY FORM**

Patient Name: _____

1. Have you ever suffered from?

	Yes	No
Heart Disease	—	—
High Blood Pressure	—	—
Heart Attack	—	—
Emphysema	—	—
Asthma	—	—
Blood Disease	—	—
Kidney Disease	—	—
Glaucoma	—	—
Diabetes	—	—
Jaundice/Hepatitis	—	—
Cancer	—	—
Anemia	—	—
Bruise easily	—	—
HIV	—	—
Facial Trauma	—	—
Allergies	—	—
Circulatory Problems	—	—
Cardiac Problems	—	—
Pacemaker	—	—
Low Blood Pressure	—	—
Hearing Problems	—	—
Vision Problems	—	—
Balance Problems	—	—
Seizures	—	—
Syncope	—	—

2. What Medications are you currently taking? _____

3. List any medical problems: _____

4. Do you have any of the following habits?

	Yes	No		
Smoking	—	—	Frequency	Years
Alcohol	—	—	Frequency	Years
Recreational Drugs	—	—	Frequency	Years

5. What medications are you allergic to? _____

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

Name of Physician: _____

Address: _____

7. Have you had a recent :

	Normal	Abnormal	Yes	No
Chest x-ray	—	—	—	—
Electrocardiogram	—	—	—	—

8. Have you ever had any previous surgery? _____

What kind/When/Where? _____

9. Have you ever consulted a professional for emotional problems? Who/When? _____

10. Do you have any caps, crowns, bridges, loose, or false teeth? ___Yes ___No

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

12. Do you have any of disease or problem not listed you feel that we should know about? _____

Patient Signature: _____ Date: _____

MultiCare Therapy Center

**Advanced Directives/"Living Will"/DNR 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

Patient Signature

Date

MultiCare Therapy Center

1527 Route 27, Suite 1500 Somerset, NJ 08873 732-545-7474 fax 732-545-2880

Authorization for Release/Receipt of Information

Patient Name _____ Date _____

I authorize the physicians/hospitals listed below to release my medical records to MultiCare Therapy Center.

(List current Physicians – Hospitals)

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

I authorize MultiCare Therapy Center to release my Medical Records to the above mentioned Physicians/Hospitals.

READ CAREFULLY: I understand that my medical records are confidential. I understand that by signing this authorization I am allowing the release of my medical information requested to the agency or persons specified above. Drug and alcohol abuse information records are specifically protected by federal regulations and by signing this authorization, I am allowing the release of any drug, alcohol, and/or psychiatric information records to the agency or persons specified above. I understand that my records may contain information regarding the diagnosis and treatment of HIV (AIDS virus) and other sexually transmitted diseases and by signing this authorization, I am allowing this information to be released to the agency or persons specified above. I also understand that I may revoke this authorization at any time by written request from myself or my family except to the extent that action has already been taken in reliance upon it.

This consent shall remain in effect for ninety (90) days from the date executed unless revoked earlier by me. If revoked earlier, it is understood by all parties that the information released prior to being notified of such revocation was made at my request with my consent.

I have read the above and foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this consent.

Date: _____ Signature: _____
(If signed by personal representative, please state relationship/authority to do so.)

Patient Name: _____ Date of Service: _____

INFORMED CONSENT FOR TREATMENT/PROCEDURE

I acknowledge that **MultiCare Therapy Center** has informed me of the following:

1. My diagnosis, if known
2. My basic rights and responsibilities as a patient
3. The nature and details of the procedure/treatment
4. The purpose of the procedure/treatment
5. The potential risks of the procedure/treatment
6. The potential benefits of the procedure/treatment
7. The alternatives available, if any
8. The risks and benefits of the alternatives
9. The potential risk if the procedure/treatment is not performed

I acknowledge that I have had an opportunity to ask all the questions I have regarding this condition or disease and concerning the available treatments and/or procedures. All questions have been answered to my satisfaction.

I understand that my Treatment Plan will be individualized to me and my needs, and will be created in consultation with my referring physician and the professional personnel of the facility including the Medical Director. This plan will be reviewed every 30 days. I will be invited to attend that review, if I desire, along with a family member or my caregiver. I give consent for MultiCare Therapy Center to discuss my case with the people I invite to attend these periodic reviews of my case.

I acknowledge that no guarantees, either express or implied, have been made to me regarding the outcome of any treatments and/or procedures. I fully understand that it is impossible to make any guarantees regarding a cure or outcome of any medical treatment or procedure.

I hereby authorize the above-named provider and designated associates and assistants to perform the treatment(s) or procedure(s) named above.

Authorized Signature

Date

FEMALES ONLY
I hereby declare that as of the date above, to the best of my knowledge, I am not pregnant. In the event that I should discover that I am pregnant, I will inform MultiCare Therapy Center. I do not hold MultiCare Therapy Center liable for any complications that may arise due to treatment.

Signature

MultiCare Therapy Center

HIPPA Notice of Privacy Practices

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

Name _____ Date _____

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 a 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 confidentiality of your Protected Information in accordance with state and federal law;
- Honor your requested restrictions regarding the use and disclosure of your Protected Information unless under the law we are authorized to release 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;
- Act on your request to amend Protected Information within sixty (60) days and notify you of any delays which would require us to extend the deadlines by the permitted thirty (30) days extension;
- Accommodate reasonable requests to communicate Protected Information by alternative means or methods; and
- Abide by the 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 or Health Care Operation: Treatment Purposes. We may disclose your Protected Information for various treatment purposes. During your care at our facility, it may be necessary for various personnel involved in your case to have access to your 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.

*Please note: We reserve the right to revise our practices with respect to Protected Information and to amend this notice. Should our information practices change, we will post notice of the change in the waiting area of this facility. In addition, current notice of our privacy practices may be obtained from Philip Chiyuto, Clinic Administrator at 732-545-7474.

MultiCare Therapy Center - Assignment of Benefits/Release of Information

Patient Name: _____

Policy Number: _____

Claim Number: _____

In consideration of services rendered or to be rendered, I hereby assign to the provider of the services and/or its assignees my first party no-fault automobile insurance benefits and rights. Attendant thereto, as shall equal the full amount of the bill for such services and the provider or its assignees may secure same in my name. I hereby assign and authorize provider to institute litigation/arbitration to collect insurance benefits on my behalf.

I further understand that if said sum is not collected, I will remain personally liable therefore.

DATE Patient's Signature or Legal Representative

If translated, signature of translator

DATE Translator's Signature

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name: _____

- I authorize MultiCare Therapy Center to furnish my insurance company or their representatives all information you may have regarding my condition while under your treatment or observation, including the history obtained, x-rays and physical findings, diagnosis and prognosis. You are authorized to provide the information in accordance with the New Jersey Automobile Preparations Act (No-Fault Law).
- I also authorize the release of test data and billing information to a licensed physician of the facility's choosing for the purposes of professional interpretation and establishment of a diagnosis and treatment recommendations.
- I confirm that I was offered a copy of the procedure for filing a grievance with the facility.
- I was given a copy of the HIPAA Privacy Practices Notice.
- I was given a copy of the Patient Rights.
- I authorize MultiCare Therapy Center to leave messages regarding my scheduled appointments on my home answering machine
- I authorize MultiCare Therapy Center to leave messages regarding my scheduled appointments with members of my household

DATE Patient's Signature or Legal Representative

NOTICE OF FACILITY LIEN

Patient Name: _____

Date of Accident: _____

I do 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, judgment 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 sustained in connection therewith.

I fully understand that I am directly and fully responsible to said facility for all medical bills submitted by the facility for the services rendered to me and that this agreement is made solely for said facility's additional protection and in consideration of their awaiting payment. I further understand that such payment is not contingent on any settlement, judgment, 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 any 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 is irrevocable.

DATE Patient's Signature

If translated, signature of translator

DATE Translator'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 ant settlement, judgement, or verdict, as may be necessary to adequately protect and fully compensate said doctor above-named.

Date

Attorney's Signature

Please date, sign, and return to facility office:

**MultiCare Therapy Center
1527 Route 27, Suite 1100
Somerset, NJ 08873
T:732-545-7474 F:732-545-2880**

ATTENDING PROVIDER TREATMENT PLAN

INITIAL SUBMISSION FOLLOW-UP SUBMISSION

TYPE OR PRINT LEGIBLY			CLAIM #:	DATE SUBMITTED	Month	Day	Year
PATIENT INFORMATION				POLICYHOLDER INFORMATION (if different)			
1. PATIENT'S NAME Last First Initial			12. DATE OF ACCIDENT		15. POLICYHOLDER'S NAME Last First Initial		
2. PATIENT'S ADDRESS (No., Street)			13. IS PATIENT'S CONDITION RELATED TO:		16. POLICYHOLDER'S ADDRESS (No.; Street)		
3. CITY		4. STATE	A. EMPLOYMENT <input type="checkbox"/> YES <input type="checkbox"/> NO		17. CITY		18. STATE
5. ZIP CODE		6. TELEPHONE # (Include Area Code)	B. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		19. TELEPHONE # (Include Area Code)		20. ZIP CODE
7. PATIENT BIRTHDATE		8. SEX <input type="checkbox"/> M <input type="checkbox"/> F	C. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		21. RELATIONSHIP TO PATIENT		
10. INSURANCE COMPANY			14. IS PATIENT UNABLE TO WORK? <input type="checkbox"/> NO <input type="checkbox"/> YES				
11. POLICY NUMBER							
PROVIDER INFORMATION							
22. NAME OF TREATING PROVIDER Last First Initial			23. TAX I.D. NUMBER		24. SPECIALTY		25. FACILITY OR OFFICE NAME
26. FACILITY/OFFICE ADDRESS (No.; Street)			27. CITY		28. STATE		29. ZIP CODE
30. TELEPHONE # (Include Area Code)		31. EMAIL ADDRESS		32. FAX # (Include Area Code)		33. INITIAL DATE OF TX	34. DATE OF LAST VISIT
35. PATIENT MEDICAL HISTORY. HAS PATIENT EVER HAD ANY OF THE FOLLOWING SERVICES? CHECKMARK THOSE APPLICABLE BELOW. (*NOTE-ALL BOXES CHECKED REQUIRE A BRIEF DESCRIPTION OF SERVICE AND DATE PROVIDED ON SEPARATE ATTACHMENT)							
<input type="checkbox"/> ALL MEDICATION		<input type="checkbox"/> MRI	<input type="checkbox"/> SURGERY	<input type="checkbox"/> X-RAY	<input type="checkbox"/> DIAGNOSTICS TESTING		<input type="checkbox"/> OTHER
36. PRIMARY DIAGNOSIS (ICD-9)		37. SECONDARY DIAGNOSIS (ICD-9)		38. ADDITIONAL DIAGNOSIS (ICD-9)		39. ADDITIONAL DIAGNOSIS (ICD-9)	
PROPOSED COURSE OF TREATMENT AS IT RELATES TO THIS MVA							
40. DATE(S) OF TREATMENT REQUESTED FROM TO			41. CHECK APPROPRIATE CARE PATH (if applicable)				
			<input type="checkbox"/> CP1	<input type="checkbox"/> CP2	<input type="checkbox"/> CP3	<input type="checkbox"/> CP4	<input type="checkbox"/> CP5
42. REQUEST FOR SERVICES : CPT / HCPS / NDC CODES (Use left box for single codes or left and right box for a range of codes)			FREQUENCY (Times per visit)	FREQUENCY (Visits per week)	DURATION (Number of weeks)	TOTAL UNITS	
42. CHECKMARK ATTACHMENTS BELOW. (*NOTE-ALL SUPPORTING DOCUMENTS CHECKED MUST BE PROVIDED ON SEPARATE ATTACHMENT)							
<input type="checkbox"/> SOAP NOTES		<input type="checkbox"/> PROGRESS NOTES		<input type="checkbox"/> TEST RESULTS		<input type="checkbox"/> MEDICAL HISTORY	<input type="checkbox"/> PRESCRIPTIONS
<input type="checkbox"/> OTHER							

FRAUD PREVENTION-NEW JERSEY WARNING

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

PROVIDER STATEMENT

I HAVE PERSONALLY COMPLETED AND REVIEWED THIS FORM. THE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

43.

SIGNATURE OF PROVIDER

DATE

APPLICATION FOR BENEFITS – PERSONAL INJURY PROTECTION

Date	Policyholder	Policy Number	Date and Time of Accident	Claim Number
1. Accident Location (Street, City or Town and State)		2. Brief Description of Accident		
		<input type="checkbox"/> Driver of Vehicle <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian		

PROVIDER'S NAME AND ADDRESS

*MultiCare Therapy Center
 1527 Route 27, Suite 1100
 Somerset, NJ 08873
 (732) 545-7474*

Name and Address of Insurer's Claims Rep

3. Patient's Name and Address		
4. Date of Birth	5. Sex	6. Occupation (if known)
7. Describe Your Injury:		
8. When did symptoms first appear? DATE: _____		9. Were you treated by a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No 10. Doctor's Name and Address:
11. At the time of your accident were you acting in the course of your employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	12. Did you lose wages or salary as a result of your injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	13. If yes, amount lost to date: \$ _____
14. What is your average weekly wage or salary? \$ _____	15. If you lost wages, Disability dates Date Disability Began _____ Date You Returned to Work _____	16. Have you received, or are you eligible for, payments under any Worker's Compensation, Unemployment Law, Medicaid or Military Benefits for this accident? <input type="checkbox"/> Yes Amount \$ _____ <input type="checkbox"/> No
17. List names and addresses of your employer and other employers for one year prior date and give occupation and dates of employment for each:		
Employer Name and Address	Occupation	From To
Employer Name and Address	Occupation	From To
Employer Name and Address	Occupation	From To
18. As a result of your injury have you had any other expenses? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes explain:		
<p>By signing this form, I am agreeing to be bound by the terms and conditions of the policy including but not limited to Pre-Certification, Decision Point Review, Voluntary Utilization, Duties of Cooperation, and Dispute Resolution. I understand that, if I knowingly file a statement of claim containing any false or misleading information I may be subject to civil and criminal penalties. I certify that I have read and understood this entire form.</p> <p>Signature: _____ Date: _____ (injured persona or representative, if a minor a parent or legal guardian shall sign.)</p>		