NJPR
COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY

Patient Registration

Patient Name: *(last)* _____ *(first)* _____ *(m)* _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: *(home)* _____ *(work)* _____ *(cell)* _____

Email: _____ Gender: M F Marital Status: S M D W

Date of Birth_____/_____/_____ Social Security: _____-_____-_____

Employer:_____ Phone:_____

Employer Address: _____

Emergency Contact: _____ Phone: _____

Referring Doctor: _____ Orthopedist – PCP – Other

Reason for visit: _____ Date of Injury/Accident: _____/_____/_____

Surgery for this injury: _____Yes _____No If yes, Date of Surgery_____/_____/_____

Result of Accident: _____Yes _____No If yes, was the accident: Auto / Workers / Comp / Other

Emergency contact: _____ Phone: _____

Do you have a Living Will/ Advanced Directive? _____Yes _____No

I have been informed of my patients' rights: *(copies are available upon request)* Signature: _____

Primary Insurance Company: _____

Insured Party: Self____ If not, *(last)* _____ *(first)* _____

Policy Holder Date of Birth _____/_____/_____ Relationship to Patient: _____

Secondary Insurance Company_____

Insured Party: Self____ If not, *(last)* _____ *(first)* _____

Policy Holder Date of Birth _____/_____/_____ Relationship to patient _____

Attorney Information: _____ Phone: _____

Address: _____

Section A 1719 NJ Statute requires the following to appear on this form. Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. I certify that the above information is correct.

Patient/Guardian Signature: _____ Date: _____/_____/_____

FOR OFFICE USE ONLY→ DOCUMENT REVIEWED BY:

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Patient Medical History

Patient Name: _____ Date of Injury: _____/_____/_____

Referring Physician: _____ Primary Care Physician: _____

Age: _____ Height: _____ feet _____ inches Weight: _____

Are you currently taking ANY prescription medications (circle one)? _____Yes _____No

___ Anti-Inflammatories ___Muscle Relaxant ___Pain Medication ___ Other Medication

Please list all other medications: _____

Do you currently have, or ever had, any of the following:

CONDITION	***Yes***	***No***
Asthma, Bronchitis or Emphysema		
Shortness of Breath or Chest Pain		
Heart Disease or Angina		
Pacemaker		
High Blood Pressure		
Heart Attack or Cardiac Surgery		
Stroke – TIA		
Blood Clot – Emboli		
Epilepsy or Seizures		
Thyroid Problems		
Anemia		
Infectious Disease		
Diabetes		
Cancer		
Arthritis		
Osteoporosis		
Gout		
Emotional or Psychological Concerns		
Bowel or Bladder Issues		

CONDITION	***Yes***	***No***
Severe of Frequent Headaches		
Vision or Hearing Difficulties		
Numbness or Tingling		
Dizziness or Fainting		
Weakness		
Weight or Energy Loss		
Hernia		
Varicose Veins		
Allergies		
Pins or Metal Implants		
Joint Replacement		
Cervical Injury or Surgery		
Lumbar – Thoracic Injury or Surgery		
Shoulder Injury or Surgery		
Elbow – Hand Injury or Surgery		
Hip – Knee Injury or Surgery		
Foot – Ankle Injury or Surgery		
Do You Smoke		
ARE YOU PREGNANT?		

Please list any information that may assist us with your treatment: _____

_____

Do you understand your diagnosis (circle one)? _____Yes _____No

What are your expectations and goals of rehabilitation? _____

Please list any other medical or rehabilitative service you have had for this injury (example – MRI, chiropractic):

_____

Patient/Guardian Signature: _____ Date: _____/_____/_____

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Social and Phycological Assessment

Patients Name: _____ Date: _____/_____/_____

Phone Number: _____ Email: _____

How is your rehabilitation treatment progressing? _____

_____

_____

Do you have any anxiety? _____

_____

Do you have any post-traumatic stress concerns? _____

_____

_____

Do you have any family concerns? _____

_____

_____

What is your pain level? (*please circle)* *least* - 1 2 3 4 5 6 7 8 9 10 - *worst*

Is the rehabilitation helping? _____

_____

_____

How are you managing your pain? _____

_____

_____

Are there any adjustment issues that need to be addressed with your rehabilitation program?

_____

_____

Would you consider a one on one consultation to address rehabilitation issues?

_____Yes _____No

Would you consider a group session?

_____Yes _____No

Patients Signature: _____

Notice of Privacy Practices

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

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, physical therapy evaluations and reports will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations. Your health information may be used as necessary to support the day-to-day activities and management of NJ Pain and Rehabilitation Center. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law-enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Individual Rights

You have certain rights under the federal privacy standards. These include:

Patient's Rights and Responsibilities (Posted in Front Waiting Area)

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

NJ Pain and Rehabilitation Center's Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We are also required to abide by the privacy policies and practices that are outlined in this notice.

Rights to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, a written request is necessary in order to inspect or copy protected health information. You may obtain a request form to access your records by contacting the receptionist or business operations director. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concern(s) to:

Charles Sara, M.S.
Executive Director
NJ Pain & Rehabilitation Center, Inc.
Professional Medical Rehabilitation, P.A.
37 W. Century Road, Suite: 111
Paramus, NJ 07652
(201) 262-2244

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause or your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Effective Date

This notice is effective on or after August 1, 2020.

NJ Pain and Rehabilitation Center, Inc.
Professional Medical Rehabilitation, P.A.

ASSIGNMENT OF BENEFITS
&
LTD. POWER OF ATTORNEY

I irrevocably assign to you, my medical provider, all of my rights and benefits under my insurance contract for payment for services rendered to me. I authorize you to file insurance claims on my behalf for services rendered to me and this specifically includes filing arbitration/litigation in your name on my behalf against the PIP carrier/health care carrier. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills. I direct that all reimbursable medical payments go directly to you, my medical provider. I authorize and consent to your acting on my behalf in this regard and in regard to my general health insurance coverage pursuant to the "benefit denial appeals process" as set forth in the NJ Administrative Code.

In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is challenged or deemed invalid, I execute this **limited/special power of attorney** and appoint and authorize your collection attorney as my agent and attorney to collect payment for your medical services directly against the carrier in this case, in my name, including filing an arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me and designate your collection attorney as my attorney in fact. I further grant limited power of attorney to you as my medical provider to receive and collect directly from the insurance carrier money due you for services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered to me. I authorize you and or your attorney to receive from my insurer, immediately upon verbal request, all information regarding last payment made by said insurer on my claim, including date of payment and balance of benefits remaining.

I authorize you and or your attorney to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider(s) to release all such information to you about me, including medical reports, X-ray reports, narrative reports, and any other report or information regarding my physical condition.

Dated: _____

_____
Patient's Signature

_____
Patient's Name (Print)

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COVID-19 Questionnaire

Full Name: _____ Date: _____/_____/_____

Phone Number: _____ Email: _____

Have you been diagnosed with Coronavirus (COVID-19)?	_____Yes _____No
If diagnosed with Coronavirus (COVID-19), were you symptomatic?	_____Yes _____No
If diagnosed with Coronavirus (COVID-19) were you hospitalized?	_____Yes _____No
Has any member of your household been diagnosed with Covid-19?	_____Yes _____No

I hereby certify that the responses provided above are true and accurate to the best of my knowledge.

Signature of Patient or Guardian: _____