Team Physical Therapy, LLC
Charles D. Sacco MSPT

798 Route 73 South
West Berlin, NJ 08091

PATIENT INFORMATION

NAME: _____ DATE OF BIRTH:_____

ADDRESS:_____ SEX: M F

_____ CELL PHONE: _____

EMAIL: _____ HOME PHONE:_____

PATIENT SOCIAL SECURITY #: _____ DIAGNOSIS: _____

REFERRING PHYSICIAN:_____ PRIMARY PHYSICIAN: _____

INJURY WORK RELATED? YES NO AUTO RELATED? YES NO

DATE OF INJURY:_____ DATE OF SURGERY:_____

EMPLOYER: _____ PHONE NUMBER: _____

HOW DID YOU HEAR ABOUT US? _____

INSURANCE INFORMATION

POLICY OWNER'S NAME: _____ POLICY OWNER'S SSN: _____

POLICY OWNER'S BIRTHDATE: _____ RELATIONSHIP TO PATIENT: _____

INSURANCE COMPANY: _____ GROUP/ID NUMBER: _____

INSURANCE CO. ADDRESS: _____ INSURANCE PHONE NUMBER: _____

POLICY OWNER'S NAME: _____ POLICY OWNER'S SSN: _____

POLICY OWNER'S BIRTHDATE: _____ RELATIONSHIP TO PATIENT: _____

INSURANCE COMPANY: _____ GROUP/ID NUMBER: _____

INSURANCE CO. ADDRESS: _____ INSURANCE PHONE NUMBER: _____

ASSIGNMENT OF BENEFITS AND MEDICAL RELEASE: I IRREVOCABLY ASSIGN TO T.E.A.M. PHYSICAL THERAPY LLC ALL MY RIGHTS AND BENEFITS UNDER ANY UNSURANCE CONTRACTS FOR PAYMENT FOR SERVICES RENDERED TO ME BY T.E.A.M. PHYSICAL THERAPY LLC. I IRREVOCABLY AUTHORIZE ALL INFORMATION REGARDING MY BENEFITS UNDER ANY INSURANCE POLICY RELATING TO ANY CLAIMS BY T.E.A.M. PHYSICAL THERAPY LLC TO BE RELEASED TO T.E.A.M. PHYSICAL THERAPY LLC. I AUTHORIZE T.E.A.M. PHYSICAL THERAPY LLC TO FILE INSURANCE CLAIMS ON MY BEHALF FOR SERVICED RENDERED TO ME. I IRREVOCABLY DIRECT THAT ALL SUCH PAYMENTS GO DIRECTLY TO T.E.A.M. PHYSICAL THERAPY LLC. I IRREVOCABLY AUTHORIZE T.E.A.M. PHYSICAL THERAPY LLC TO ACT IN MY BEHALF AND REPORT ANY SUSPECTED VIOLATIONS OF PROPER CLAIMS PRACTICES TO THE PROPER REGULATORY AUTHORITIES. THIS ASSIGNMENT OF BENEFITS HAS BEEN EXPLAINED TO MY FULL SATISFACTIONS AND I UNDERSTAND ITS NATURE AND EFFECT.

PATIENT SIGNATURE:_____ DATE : _____

AUTHORIZED PERSON:_____ RELATIONSHIP: _____

MEDICAL HISTORY

REFERRING PHYSICIAN: _____ FAMILY PHYSICIAN: _____

CHIEF COMPLAINT: _____

CONDITION	YES	NO	NOT SURE	EXPLANATION
Cardiac (heart problems)				
Pacemaker				
Chest, Jaw, or left arm pain				
Respiratory				
Shortness of Breath				
Seizures (epilepsy)				
Stroke				
Hypertension (high blood pressure)				
Dizziness or fainting				
Arthritis (joint disease)				
Fractures (broken bone)				
Cancer				
Surgery				
Vision problems				
Hearing difficulty				
Are you taking any medications?				
List your medications:				
Allergies?				
Are you pregnant?				
Are you a nervous person?				
Are you under physician's care for any other condition?				

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP TO PATIENT: _____

PHONE NUMBER: _____ SECONDARY PHONE NUMBER: _____

I VERIFY, THAT THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE

PATIENT SIGNATURE:_____ **DATE**:_____

CONSENT FOR OUTPATIENT SERVICES
AUTHORIZATION TO PAY INSURANCE BENEFITS AND RELEASE MEDICAL INFORMATION

I, the undersigned, do hereby voluntarily consent to evaluation and/or treatment, and authorize whomever he/she may designate, including physician(s), therapist(s), etc. to direct or administer such treatments as are therapeutically necessary.

I have been informed of any of my rights and responsibilities as a patient.

I have received a copy of T.E.A.M. Physical Therapy LLC Privacy Notice and may obtain an additional copy upon request.

I understand that it is my responsibility for charges not covered by my insurance and I agree to pay all balances remaining after my insurance has made payment.

A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

SIGNATURE OF PATIENT: _____ **DATE: _____**

SIGNATURE OF WITNESS: _____ **DATE: _____**

OFFICE POLICY

The following outlines the policy at T.E.A.M. Physical Therapy and any excess fees that would become the patient's responsibility. Patient's statements will be billed monthly with any outstanding balance in the account. Once 3 cycles of billing the same balance have occurred, the account will be turned over to a collections agency.

Copay and Coinsurance:

We look into patients insurance to obtain a copay information as a courtesy. It is ultimately the patient's responsibility to know their own insurance.

Bounced Check Fees:

In the event of a bounced check, there will be a $30 fee applied to the patient's account in addition to the original check amount.

Missed Appointment Fee:

We require 24 hour notice for all routine office visits; otherwise a $25 missed appointment fee will be charged.

1. 1st missed follow up appointment: We'll call and offer to reschedule patient's appointment. Patient may be charged a missed appointment fee of $25.
2. 2nd missed follow up appointment: Patient will receive written notification of their missed appointment and be charged a fee of $25.
3. 3rd missed follow up appointment: Patient will be charged an additional missed appointment fee of $25.

SIGNATURE OF PATIENT: _____ **DATE: _____**

SIGNATURE OF WITNESS: _____ **DATE: _____**