Progression Physical Therapy
of Princeton, LLC

In order to provide quality treatment to you and to all of our patients, we kindly request that you give 24 hours advanced notice of cancellation. This will give us the opportunity to schedule another patient into that treatment time. Cancellation without appropriate notice will result in a fee charge of $45.00. Sickness and family emergency are exempt from this policy.

Thank you for your consideration,
Progression PT

Please initial: _____

Revised 10/2020

Progression PT of Princeton, LLC

1. **Informed Consent for Physical Therapy Treatment:** I give consent and permission for ***Progression PT of Princeton, LLC*** and its licensed physical therapists to administer medically necessary physical therapy services. It is the intent of *Progression PT of Princeton, LLC* to provide education regarding patients' rights and clinic policies to every patient.

2. **Assignment of Benefits:** I hereby authorize my insurance benefits be paid directly to ***Progression PT of Princeton, LLC***. I understand that I am financially responsible for non-covered services by my insurance company. I acknowledge that if ***Progression PT of Princeton, LLC*** does not contract with my insurance company, I will be responsible for the difference between what is charged and what my insurance pays.

3. **HIPAA Acknowledgement Form:** Please see "Your Information, Your Rights, Your Responsibility" booklet located at the front desk. I acknowledge that I have received a copy of the ***Progression PT of Princeton, LLC*** Notice of Private Practices. I understand that the notice describes how ***Progression PT of Princeton, LLC*** uses and discloses my medical and billing information. The notice also describes my rights and how I can receive additional information.

4. **Cancellation/No-Show Policy:** I agree that ***Progression PT of Princeton, LLC*** has a cancellation/no-show policy in place to protect the time of patients and staff. I am aware of a $45.00 fee in the event that I choose not to attend a scheduled appointment or cancel in less than a 24-business hour period from my scheduled visit (weather excluded). Out of mutual respect, ***Progression PT of Princeton, LLC*** will make every effort to provide a 24-hour notice to the patient for any appointment times that need to be rescheduled or cancelled due to unforeseen circumstances.

5. **Release of Medical Information:** I hereby authorize ***Progression PT of Princeton, LLC*** to obtain any and all medical records needed to aid my evaluation and treatment in physical therapy. I further give consent to release any medical information and bills to necessary third parties for the purpose of review, case record and payment. ***Progression PT of Princeton, LLC*** may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies, law requirements or for emergencies. In any other situation, ***Progression PT of Princeton, LLC*** policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures any time. You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes. If you are concerned that ***Progression PT of Princeton, LLC*** may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact Ruth Kaplan, privacy officer, at 601 Ewing St, Suite B-9, Princeton, NJ. You may also send a written complaint to the US Department of Health and Human Services.

Signature: _____ Date: _____

My signature confirms that I am in acknowledgement of the above statements.

Revised 02/2021

Progression Physical Therapy
Of Princeton, LLC

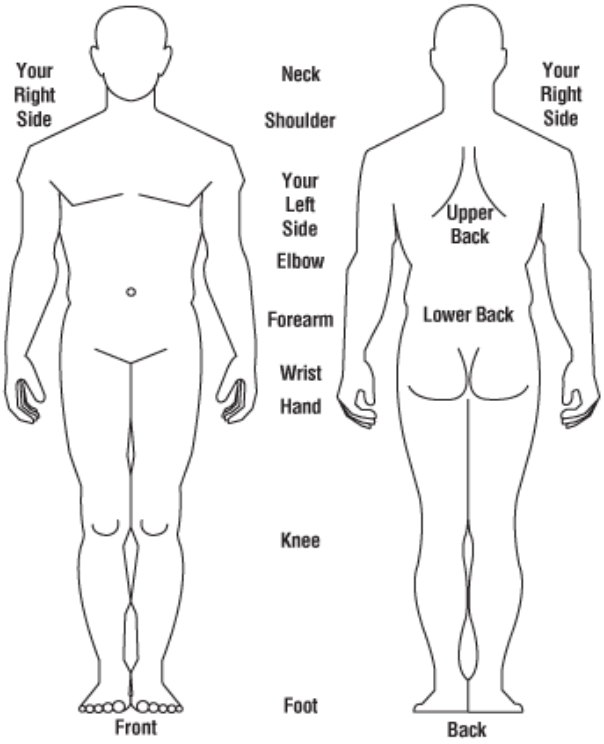
Circle one number that corresponds to the WORST amount of pain you have experienced **in the last week**; then circle another number that corresponds to the LEAST amount of pain you have experienced **in the last week.**

0	1	2	3	4	5	6	7	8	9	10
None	→ Slight	---------- → Moderate	---------- → Severe	---------- → Extreme	---------- → Worst					

Please shade in the areas where you have symptoms. Circle the nature of your pain:
Sharp, Dull/Achy, Numbness, Tingling, Burning, Shooting

How is your condition changing?
( ) Getting Better
( ) Not Changing
( ) Getting Worse

How often are your symptoms present during the day?
( ) Constantly (76-100%)
( ) Frequently (51-75%)
( ) Occasionally (26-50%)
( ) Intermittently (0-25%)



Have you had current x-rays, MRI, CT Scan for your area(s) of complaint? ( ) YES ( ) NO

Would you say your overall health right now is: ( ) Excellent ( ) Good ( ) Fair ( ) Poor

I certify to the best of my knowledge that all of the above information is true and correct as of the date below:

Patient/Responsible Party
Signature:_____Date:_____

Revised: 02/2021

***Progression* PT of Princeton, LLC**

Under Medicare and the NJ practice act, we are required to obtain a complete medical history on all patients. This information is protected under the HIPAA laws.

Name:_____

Current Medications:_____

Medical History and Review of Symptoms: Please check all that apply.

- ☐ Cardiac Issues _____
- ☐ Pacemaker
- ☐ Diabetes Type 1 / Type 2 (circle one)
- ☐ Neuropathy (decreased sensation)
- ☐ Recent Falls (in last 2 years)
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Peripheral Vascular Disease
- ☐ Swollen Ankles or Feet
- ☐ History of Stroke/TIA
- ☐ Dizziness/Vertigo (circle one)
- ☐ Fainting
- ☐ Osteoporosis/Osteopenia (circle one)
- ☐ Other Bone Disease
- ☐ Osteoarthritis/Gout (circle one)
- ☐ Rheumatoid Arthritis
- ☐ Swollen/Red or Warm Joints
- ☐ Respiratory Disorders
- ☐ Allergies/Sinus issues
- ☐ Women: I am or may be pregnant

- ☐ Autoimmune Disorder Type: _____
- ☐ Cancer Type:_____
- ☐ Kidney Disorders
- ☐ History of Blood Clots
- ☐ Transplants
- ☐ Stomach Ulcers/Stomach Pain
- ☐ Bleeding Disorders
- ☐ Infectious Disease
- ☐ Hepatitis/Liver Disorders
- ☐ Recent Weight Change
- ☐ Very Low Energy
- ☐ Alcohol Dependence
- ☐ Depression/Anxiety/Mental Illness (Circle one)
- ☐ Poor Balance
- ☐ Vision Problems/Changes in Vision
- ☐ Hearing Loss
- ☐ Seizures
- ☐ Headaches
- ☐ Other:_____

Pertinent Surgical History:_____
_____

Evaluating Physical Therapist's Signature:_____
(Signature is a testimony of medical history review)

Revised 02/2021

Progression **Physical Therapy**
of Princeton, LLC

PATIENT INFORMATION FORM

Name:_____Date of Birth:_____

Address:_____City, State, Zip:_____

Home/Cell Phone:_____Email:_____

Occupation:_____Employer:_____

Emergency Contact: Name/Phone/Relationship:_____

Referring Physician:_____Primary Physician:_____

Have you had other Physical Therapy this current year?_____YES / NO

PRIMARY HEALTH INSURANCE COMPANY_____
SECONDARY HEALTH INSURANCE COMPANY_____

RESPONSIBLE PARTY: SAME AS PATIENT ( )

Policy Holder's Name:_____Holder's DOB:_____

Relationship to Insured:_____Home or cell phone:_____

A copy of your insurance card and prescription (if needed) will be added to your file at your first visit**. Please be familiar with your insurance's Physical Therapy Benefits (copays, deductible, plan type.)** You will be responsible for all co-pay's, and deductibles per insurance plan. The required **copay must be paid at the time of visit with check, cash, or credit card.** We will safely guard use your credit card information. We use the card only in the case of a no show or CANCEL without appropriate 24 business hour notice.

TYPE OF CARD:_____NAME ON CARD:_____

CREDIT CARD NUMBER:_____EXP. DATE_____

I certify that, to the best of my ability, all of the above information is true and correct as of the date below:

Signature:_____Date:_____

Revised 02/2021