PRE-INTAKE FORM: SCERBO PHYSICAL THERAPY & SPORTS MEDICINE INSTITUTE, LLC

Past Patient: YES❑ NO❑	**Patient Name: (First, MI, Last, Sr., Jr., etc...)**		**SS#**	
Address:		**City:**	**State:**	**Zip Code:**
Telephone:	**Email:**	**Date of Birth: (mm-dd-yy)**	**Sex** M❑ F❑	**Status:** ❑ Single ❑ Married ❑Divorce ❑ Widowed ❑ Separate ❑ Unknown
Date of Injury / Onset Date:	**Auto Related:** ❑ Yes State? _____ ❑ No	**Work Related:** ❑ Yes ❑ No	❑	**Adjustor Name & Telephone #:**
If Work Comp., was accident with present Employer? ❑ Yes ❑ No If no, who was employer? _____				**If Auto Accident: Date of Accident:** ___/___/___ **Type of Accident:** Driver / Passenger / Pedestrian / Job / Fall / Other

Do you have Medicare? ❑ Yes ❑ No

Are you currently receiving Home Health Services? ❑ Yes ❑ No

If Yes, name of agency & what type of Home Health Services are you receiving? _____

If No, have you received services in the past 60 days__ If yes, Name of Agency & Last Date of Service _____

Were you ever treated for Out Patient Therapy before? ❑ Yes ❑ No

Primary Insurance Information

Name of Insurance Company:	**Policy or Claim #:**	**Group # / Policy Holder Employer:**
Policy Holder Name:	**Date of Birth:**	**Social Security #:**
Insurance Company Telephone:	**Policy Holders Work Phone #:**	**Patient Relationship to Policy Holder:** ❑ Self ❑ Spouse ❑ Dependent ❑ Other

Secondary Insurance Information (Backup if Auto, Workers Comp, or Litigation)

Name of Insurance Company:	**Policy or Claim #:**	**Group # / Policy Holder Employer:**
Policy Holder Name:	**Date of Birth:**	**Social Security #:**
Insurance Company Telephone:	**Policy Holders Work Phone #:**	**Patient Relationship to Policy Holder:** ❑ Self ❑ Spouse ❑ Dependent ❑ Other

Employer Information

Employer Name:	**Employer Phone #:**		**Employment Status:** ❑ None ❑ FT ❑ PT ❑ Self-Emp. ❑ Retired ❑ Student
Address:	**City:**	**State:**	**Zip Code:**
Contact Name:	**Phone:**		**Relationship to Patient:** ❑ Parent ❑ Spouse ❑ Sibling ❑ Other

Physician Information

Name of refering Physician:		**Telephone #:**	
Address: (Only required if new referring Physician)	**City:**	**State:**	**Zip Code:**

Attorney Information

Attorney Name:	**Attorney Phone:**	**Address:** **State:**	**City:** **Zip Code:**

I_____authorize Scerbo Physical Therapy & Sports Medicine Institute, LLC to treat me as per my doctor's prescription and to release to my insurance company / Lawyer / Employer any Information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating claims for benefits.

Date: _____ **Signature:** _____

SCERBO
PHYSICAL THERAPY & SPORTS REHABILITATION

725 River Road, Suite 60
Edgewater, NJ 07020
scerbopt.com

Office: 201.941.2240
Fax: 201.941.2250
Email: info@scerbopt.com

NOTICE OF PRIVACY PRACTICES:

THIS NOTICE DESCRIBES HOW MEDICAL INFORAMTION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE READ IT CAREFULLY.

Our Commitment here at Scerbo Physical Therapy & Sports Medicine Institute, LLC is to serve our customers with professionalism and caring, being sure at all times to protect the privacy and security of all Protected Health Information. The following are some examples:

Insurance Companies in order to pay claims may request certain information.
Other treating physicians.

During the course of serving your interests, it may be necessary to share information with other Health Care Providers or Business Associates.

We at Scerbo Physical Therapy & Sports Medicine Institute, LLC are committed to obeying all Federal, State, and Local laws and regulations regarding Privacy Practices. If any other uses or disclosures others than the ones listed above are needed, information will only be released with the written consent of the individual in question. This written authorization may be revoked at any time by the individual, as provided for by law.

If you have any questions or comments regarding your protected Health Information, feel free to contact us.

I have read and understand the above Notice of Privacy Practice.

Signed _____ Date _____

SCERBO
PHYSICAL THERAPY & SPORTS REHABILITATION

725 River Road, Suite 60
Edgewater, NJ 07020
scerbopt.com

Office: 201.941.2240
Fax: 201.941.2250
Email: info@scerbopt.com

ASSIGNMENT OF BENEFITS

Patient Name: _____ Employer: _____

Insurance ID: _____ SSN: _____

I hereby instruct and direct _____ Insurance Company to pay by check made out to and mailed to:

Scerbo Physical Therapy & Sports
Medicine Institute, LLC
725 River Road, Suite 60
Edgewater, NJ 07020
TAX ID: 203705297

In the event that my current policy prohibits direct payments to providers, I hereby also instruct and direct you to make out the check to me and mail it as follows:

Scerbo Physical Therapy & Sports
Medicine Institute, LLC
725 River Road, Suite 60
Edgewater, NJ 07020

For the professional or medical expense benefit allowable, and otherwise payable to me under my current insurance policy as payment toward the total changes for the professional 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 have agreed to pay, in a current manner, any balance of said professional service changes over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

This patient authorizes the provider to deposit checks received on patient's account when made out to the patient.

I also authorize this provider of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize this provider to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signature _____ Date _____

Witness _____

SCERBO
PHYSICAL THERAPY & SPORTS REHABILITATION

725 River Road, Suite 60
Edgewater, NJ 07020
scerbopt.com

Office: 201.941.2240
Fax: 201.941.2250
Email: info@scerbopt.com

PATIENT MISSED APPOINMENT POLICY

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well-being and gain of your physical abilities is something every one in our clinic takes quite seriously.

We realize this would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need and to the actions we ask of you.

Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore we have certain rules that need to be followed in order to ensure the most optimum results.

We expect you to keep all your appointments. Write down the time of your visits so that you **do not forget.**

With the exception of serious emergencies it is expected that you keep all your appointments. If you need to re-schedule an appointment we require a 24-hour notice. In such a case, please call our office and arrange for a make-up appointment with the Office Administrator. The make-up appointment needs to be in the same week, preferably the very next day.

In an instance of a cancellation without 24 hours notice or no-show to a scheduled appointment, we reserve the right to charge you a **$25.00** fee.

In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care and will inform your physician of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

Scerbo Physical Therapy & Sports Medicine Institute, LLC.

I have read and understand this policy:_____ Date _____