CARUSO
PHYSICAL THERAPY
AND NUTRITION, LLC

Please use this guide as a tool to identify where you want to head with your recovery and identify areas or pieces that may be missing in your wellness. Simply check the answers that best apply to you and put a star next to the areas of higher importance to you.

This will enable us to determine where you are at with your wellness and allow us to work together to fix any cracks in your wellness that you want filled. Then, most importantly, we can provide the most direct and efficient care to get you to where you want to be.

Medical Information Sheet

Name:_____ Date: _____

Age: ____ Gender:_____ Height: ____ Weight: ____ Highest Wt: ____ Goal Wt:_____

Occupation: _____ Presently working: Y N

Reason for being seen today: _____Date of Onset: _____

Past Medical History: _____

Have you ever worked with a registered dietitian?_____

Previous weight loss programs you've tried?_____

What worked or didn't work about the weight loss programs you've tried?_____

Physician: _____ Diagnosis: _____

Did you have gastric bypass surgery? Y N Which bariatric procedure: _____ Date:_____

Have you ever been diagnosed with any of the following conditions?

Y N Asthma	Y N Headaches	Y N Kidney Problems
Y N Cancer	Y N Heart Attack	Y N Low Blood Pressure
Y N Chest Pain	Y N Heart Disease	Y N Osteoporosis/ Osteopenia
Y N Depression	Y N Hepatitis	Y N Osteoarthritis
Y N Diabetes I or II	Y N Hernia	Y N Pacemaker/Defib
Y N Dizziness/ Vertigo	Y N High Blood Pressure	Y N Pregnant
Y N Emphysema/Bronchitis	Y N HIV	Y N Seizures
Y N Fainting	Y N Joint Replacements	Y N Stroke

Please list all current medications: _____

_____

Indicate any activities that you have difficulty completing (walking, sitting, running, climbing stairs)_____

_____

_____

Where did the weight gain start?

___ Face ___ Neck ___ Arms ___ Back

___ Belly ___ Hips ___ Legs

Other, please explain: _____

Where has the weight gain spread?

___ Head ___ Neck ___ Shoulders ___ Upper Back ___ Middle Back

___ Lower Back ___ Hips ___ Legs ___ Knees ___ Ankles

___ Heels ___ Arches Other, please explain: _____

Where has the weight gain caused pain?

___ Head ___ Neck ___ Shoulders ___ Upper Back ___ Middle Back

___ Lower Back ___ Hips ___ Legs ___ Knees ___ Ankles

___ Heels ___ Arches Other, please explain: _____

What type of work do you do?

___ Bending ___ Driving ___Lifting ___ Manual Labor ___ Office

___ Outdoor ___ Sitting ___ Squatting ___ Standing ___ Telephone

___ Traveling ___ Typing Other, please explain: _____

What type of activities is your injury preventing you from doing?

_____

_____

What types of programs have you tried?

___ diets ___ gym memberships ___ Medications ___ surgeries

Other, please explain: _____

When would you like to resume your normal activities and achieve optimum wellness?

___ Yesterday ___ In the near future ___ I'm in no hurry ___ As soon as possible

What days would you be available to achieve your goals?

___ Mon ___ Tues ___ Wed ___ Thurs ___ Fri

When would you like to start?

___ Today ___ This week ___ Sometime soon ___ Not sure I need it

Do you have any specific activities or deadlines that need to be met?

Please explain: _____

_____

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New Patient Referral and Insurance Verification Form

Today's Date: _____ Prior Patient: Y N

How did you hear about our practice? Physician: Dr._____, Internet: _____, Family/Friend:_____, Advertising:_____, Insurance:_____, Other:_____.

Patient Information:
Name: _____
Address: _____ Birthdate: _____
_____ Email: _____
Home Phone: _____ Cell: _____

Referring Physician: _____ Ref Phys Phone: _____

Primary Physician: _____ Prim Phys Phone: _____

Emergency Contact Information:
Name: _____
Phone Number: _____ Relationship: _____

If patient under the age of 18, please fill out the Guarantor information below:
Guarantor Name: _____ Guar. Phone: _____
Address: _____ Relationship: _____

****REMEMBER: You need a REFERRAL (different from a prescription) from their Primary Care Physician specific to Caruso Physical Therapy and Nutrition, LLC if your insurance plan requires one.****

Insured Information (If different from patient)
Insured/ Sponsor Name:_____
Employer or Military Branch:_____
Relationship:_____ Insured DOB:_____

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Patient Information Consent Form

I have read and fully understand Caruso Physical Therapy and Nutrition's Notice of Information Practices. I understand that Caruso Physical Therapy and Nutrition may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluate the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the company in writing. I also understand that Caruso Physical Therapy and Nutrition will consider requests for restriction on a case by case basis, but does not have to agree to request for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Caruso Physical Therapy and Nutrition's and Notice of Information Practices. I understand that I retain the right revoke to this consent by notifying the company in writing at any time.

Insurance Information

As a courtesy to our patients, we will verify and file your insurance claim, **HOWEVER**, we cannot guarantee payment by your insurance company. It is your responsibility to read your policy manual as it pertains to nutrition coverage. Many insurance companies have stipulations, such as usual and customary rates (UCR), written referral requirements, limitation to number of therapy visits, limitations to reimbursable amounts per session, deductibles, coinsurance portions, copayments, limits on supplies, etc. Such stipulations should be indicated in your policy manual, if not, we recommend that you contact your insurance company directly.

YOU ARE RESPONSIBLE FOR AMOUNTS NOT COVERED BY YOUR INSURANCE. We have an agreement with YOU, not your insurance company, for receipt of payment. Please be aware of this and plan to make payments accordingly. Benefits will be verified for Workers' Compensation and Automobile Accident Claims, however, this does not guarantee payment. In the event of denial or exhaustion of benefits, this account becomes YOUR RESPONSIBILITY.

_____
Patient Name

_____
Signature

_____
Date

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Notice of Patient Information Practices

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

Caruso Physical Therapy and Nutrition LEGAL DUTY

Caruso Physical Therapy and Nutrition is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Caruso Physical Therapy and Nutrition uses your personal health information primarily for treatment, obtaining payment for treatment, conduction internal administrative activities, and evaluation the quality of care that we provide. For example, Caruso Physical Therapy and Nutrition may use your personal health information to contact you to provide appointment reminders, or information about treatment alternative or other health related benefits that could be of interest to you.

Caruso Physical Therapy and Nutrition may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, and for emergencies. We may provide de-identified information for research studies. We also provide information when required by law.

In any other situations, Caruso Physical Therapy and Nutrition's 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 at any time.

Caruso Physical Therapy and Nutrition may change its policy at any time. When changes are made, a new notice of information practices will be posted in a common area of our clinic. You may also request an update copy of our Notice of Information Practices at any time.

PATIENTS' INDIVIDUAL RIGHTS

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.

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. Caruso Physical Therapy and Nutrition will consider all such requests on a case by case basis, but the company is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Caruso Physical Therapy and Nutrition 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, you may send a written complaint to the US Department of Health and Human Services.

FINANCIAL RESPONSIBILITY/ ASSIGNMENT OF BENEFITS

Thank you for choosing Caruso Physical Therapy and Nutrition, LLC for your rehabilitation needs. As healthcare benefit and coverage options continue to increase in complexity, we have developed financial policies to assist you in understanding your responsibilities as a patient. This form is intended to communicate your financial responsibilities as a patient.

FINANCIAL RESPONSIBILITY

I understand that my insurance contract is between me, my employer and the insurance company and that Caruso Physical Therapy and Nutrition, LLC is not a party to that contract. I understand that Caruso Physical Therapy and Nutrition, LLC will contact my insurance company (including Medicare) to verify my benefits, but that it is my responsibility to understand what is covered and required under my policy. I acknowledge that providing accurate insurance and other information is critical to determining patient eligibility and benefits available.

I understand that Caruso Physical Therapy and Nutrition, LLC will bill my insurance carrier (including Medicare) for services rendered upon verification of coverage by my insurance company. I understand that verification of benefits is not a guarantee of payment and my financial responsibility is subject to change. If my insurance company fails to render payment for services rendered, I hereby personally guarantee payment for medical care and services rendered. If my insurance company does not remit payments, including if I am denied benefits under workers compensation, I understand that I will be responsible for the balance due in full.

I understand that I am responsible for paying my co-payments; co-insurance (including co-insurance from Medicare) and deductibles at the time of service which I acknowledge may be an estimate at that time. Further, I understand that laws and insurance company contracts prevent Caruso Physical Therapy and Nutrition, LLC from adjusting, writing off or waiving co-payments, co-insurance (including co-insurance from Medicare) and deductibles.

Pursuant to the assignment of benefits herein; I hereby request that my insurance carrier make payment directly to Caruso Physical Therapy and Nutrition, LLC for all services rendered by this facility. If my current policy prohibits direct payment to Caruso Physical Therapy and Nutrition, I hereby instruct and direct my insurance carrier to make the check out in my name but send the check to: Caruso Physical Therapy and Nutrition, LLC 1278 Yardville-Allentown Road Suite 3 Allentown, NJ 08501. If my insurance carrier makes payments to me I agree to immediately pay over these funds to Caruso Physical Therapy and Nutrition, LLC. I also authorize Caruso Physical Therapy and Nutrition, LLC, to deposit check received on my account when made out to me.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

ASSIGNMENT OF BENEFITS

I, the undersigned, hereby assign to Caruso Physical Therapy and Nutrition, LLC (hereinafter "Assignee") any and all rights, claims, benefits, and causes of action for personal injury protection benefits and medical payment benefits available to me under the policy affording coverage to me for any and all treatment, services, and medical claims resulting from an automobile accident that occurred. This is to act as an assignment of my rights and benefits to the extent of Assignee's services provided. In the event that I do not have insurance coverage, I understand that I remain personally responsible for payment of services rendered including all costs of collection, including attorney's fees and costs.

ASSIGNMENT OF CAUSE OF ACTION

I hereby assign by this instrument all rights and causes of action in tort, in contract and the laws of New Jersey against the personal injury protection carrier for its failure to pay for services rendered unto me by Assignee in relation to my accident that occurred.

Please call our Office if you have any questions on your account or if you are unable to pay your balance in full they will be able to discuss payment arrangements with you. The number is 609-738-3143.

_____

Print Name of Patient

_____ _____

Print Name of Guardian (if applicable) Relationship to Patient (if applicable)

_____ _____

Patient/Guardian Signature Date