



- 50 E. Gloucester Pike • Barrington, NJ 08007 •856.547.4422 •Fax: 856.547.0660
- 205 Madison Ave • Lumberton, , NJ 08060 •609.261.3354 •Fax: 609.261.8814
- Katz JCC, 1301 Springdale Rd • Cherry Hill, NJ 08003 •856.424.4444 •Fax: 856.673.2589
- New Albany Professional Bldg, 2800 Rt. 130 North, Ste 104 • Cinnaminson, NJ 08077 •856.829.0499 •Fax: 856.829.1899

[www.rehabconnection.org](http://www.rehabconnection.org)

Dear new patient,

We would like to take this opportunity to welcome you to **Rehab Connection**. We are confident that you will be completely satisfied with our facility as well as our staff.

We accept most insurance plans and our staff personally verifies your coverage prior to your first visit. You will be notified if there are any problems with your benefit plan. If you are a Medicare patient, please be advised, Medicare has re-instated the annual cap for all outpatient therapy services. Medicare also requires a certified plan of care every 30 days to continue therapy.

Our Billing Manager is available Monday through Friday from 10 am to 4 p.m. to answer any billing/insurance questions. Feel free to stop into the Barrington office or call the Billing Department at (856) 310-1249.

We have a therapist on staff daily with evening hours on Mondays, Wednesdays and Thursdays. Please feel free to call during those hours if you have any questions/concerns. Should you call when the therapist is not in the office, your call will always be returned upon receipt of the message.

Again, we would like to welcome you to **Rehab Connection**.

Sincerely,

Amy Knecht, PT, DPT, MHS QA03869

Michele Warren, PT, DPT, MHS QA03884

**TO: All Medicare Patients**  
**FROM: Billing Department**  
**DATE: January 1, 2011**  
**RE: MEDICARE CAP**

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Thank you for choosing Rehab Connection for your outpatient physical/occupational therapy needs. Medicare has implemented a limit on the amount they will cover for your therapy.

Medicare will allow a maximum payment of \$1870 for outpatient physical/speech therapy combined and \$1870 for occupational therapy. This means, after your deductible of \$162 has been met, Medicare will pay 80% (\$1496.00) and you will be responsible for the additional 20% (\$374.00) if you do not have a secondary insurance.

Generally this allowance translates to an average of 12 visits depending on the type of service rendered. Medicare also requires each patient to have a prescription from your referring physician as well as a certified plan of care.

Should you require additional therapy services after your Part B limit has been reached, your therapist will discuss other options for continued care. In the event you decide to continue treating with Rehab Connection, your insurance may not cover your treatment and the patient/patient's power of attorney will be financially responsible for services rendered.

If you have any questions, please feel free to speak with the Billing Department. We will be happy to assist you.

**PATIENT REGISTRATION FORM**

Patient Name: \_\_\_\_\_ Home Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_  
Emergency contact \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Name & Phone #: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Would you like a text msg appointment reminder?  
Yes No If Yes, Cell # \_\_\_\_\_ Sex: Male Female  
How did you hear about us? (Check ALL that apply) ? Physician? Friend/Family ? Website  
? Other \_\_\_\_\_  
Referring Physician: \_\_\_\_\_ Primary Physician : \_\_\_\_\_  
Address: \_\_\_\_\_ Address: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Phone #: \_\_\_\_\_

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Insured's Name: \_\_\_\_\_ Self Spouse Child Other  
Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Social Security#: \_\_\_\_\_  
Sex: Male Female  
Primary Insurance Information: Secondary Insurance Information:  
Insurance Co: \_\_\_\_\_ Insurance Co: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Id / Policy #: \_\_\_\_\_ Id / Policy #: \_\_\_\_\_  
Group #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

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- Have you received therapy at another facility? Y N
- If yes, please explain where, when, how many visits and for what injury?  
\_\_\_\_\_
- Is this injury post-surgical? Y N
- Is your injury a result of an automobile accident? Y N
- Is your injury a result of a work-related accident? Y N
- Is your injury a result of a slip and fall accident? Y N
- Is your injury a result of any other type of accident? Y N
- Do you have an attorney? Y N

Attorney's name: \_\_\_\_\_ Telephone#: \_\_\_\_\_  
Address: \_\_\_\_\_

If you answered yes to any of the above questions, please supply all listed documents that apply: police report, incident report, auto insurance card, insurance declaration page, driver's license, claim #, adjuster name and telephone #. (Additional information may be requested.)

**INTAKE FORM REVIEWED BY:** \_\_\_\_\_ **(Rehab Connection Employee)**



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**ASSIGNMENT OF BENEFITS**

I authorize payment of Medicare/Insurance benefits to be made directly to Rehab Connection on my behalf for physical/occupational therapy services rendered. I also authorize Rehab Connection to release my protected health information for treatment and billing purposes.

Initials \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES**

I have received a written copy of Rehab Connection’s Notice of Privacy Practices. The notice provides, in detail, the uses and disclosures of my protected health information that may be made by Rehab Connection, my rights as the patient, and Rehab Connection’s legal duties with respect to my protected health information.

Initials \_\_\_\_\_

**FINANCIAL POLICY**

As a courtesy, Rehab Connection will pre-verify your insurance benefits. Please note: Unless you have secondary insurance, all co-pays, deductibles, and/or co-insurance is the patient’s/guardian’s (in case of a minor) responsibility. Co-pays are due at the time services are rendered. Your deductible/co-insurance will be billed to you once we have received an “Explanation of Benefits” from your insurance carrier.

Balances older than 60 days will accrue interest at a rate of 3% per month. There is a \$25 fee for returned checks. Collection and billing fees will be charged to any account billed multiple times.

\*Payment methods include: cash, check, money order, Visa, MasterCard, and Discover.

Initials \_\_\_\_\_

**MEDICARE PATIENTS**

I have been informed of the Medicare cap for outpatient therapy services.

Initials \_\_\_\_\_

**CANCELLATION/NO-SHOW POLICY**

Rehab Connection urges you to keep every appointment, as consistent treatment will increase a speedy recovery. We require 24 hours notice if you need to cancel an appointment. Patients who cancel without proper notice or fail to show up for scheduled appointments will be subject to \$25 charge.

Initials \_\_\_\_\_

**SIGNATURE ON FILE**

I have read and understand the above policies and procedures.

\_\_\_\_\_  
Patient’s/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Reviewed By

\_\_\_\_\_  
Date



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To Our Patients:

Rehab Connection is requesting our patients to keep a credit card on file. Your credit card information, as all of your private information, will be kept in a secure location and used only with your permission. Only co-pays, deductibles and co-insurance will be billed to your card. This will benefit you, our valued patient, in that you will not have to write multiple checks and mail them; you will no longer receive multiple bills; and you won't have to keep track of multiple receipts for income tax purposes.

Payment on file, in no way compromises your right to dispute or question patient balances, non-covered charges, etc. Our staff, as always, is here to assist you with any questions or concerns you may have.

Sincerely,

Tynetta Leary  
Billing Manager  
Rehab Connection  
(856) 547-4422

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**OPTION 1:** I, \_\_\_\_\_, authorize Rehab Connection, PC to charge co-pays, deductible and/or co-insurance balances on my account to the following credit card:

\_\_\_ Visa                      \_\_\_ MasterCard                      \_\_\_ Discover

Account Number \_\_\_\_\_ Exp Date \_\_\_\_\_

Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_

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**OPTION 2:** I do not authorize credit card charges at this time. I agree to pay co-pays at the time of service. I understand that returned checks and balances older than 60 days are subject to additional charges as stated in Rehab Connection's financial policy.

Print Name \_\_\_\_\_ Patient (if minor) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_



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## Patient Disclosure Authorization Form

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I authorize disclosure of my protected health information to the individual(s) named below.

Name	Relationship to Patient
_____	_____
_____	_____
_____	_____

Description of information to be released: (please check all that apply)

- Appointment Times
- Medical Records Release
- Billing Information
- Other (specify): \_\_\_\_\_

This authorization provides that:

- ◆ I may revoke this authorization at any time, provided that my request is made in writing to Rehab Connection.
- ◆ Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by HIPAA rules and regulations.
- ◆ I have a right to access my protected health information that will be used or disclosed.
- ◆ I will receive a copy of this completed and signed authorization form.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient (if signed by personal representative):

\_\_\_\_\_



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## **Consumer News Service and Patient Email Newsletter**

### **Consumer News Service**

In recognition of the challenges regarding issues of insurance coverage, benefit authorization, and payment for services, we suggest that you participate in our Consumer News Service. This is an email notification service to alert you when important issues that may affect your rights to access Physical Therapy services in the State of New Jersey. It is solely to keep you apprised of the news that can directly impact your health and well being.

### **Patient Email Newsletter**

As a valued patient, it is our hope that you will appreciate complimentary information that may aid in your recovery, injury prevention and overall wellness. We periodically send interested clients a newsletter with important information, physical therapy and wellness news, company updates, and more.

**We are requesting your permission to provide you with this valuable information throughout the year. If, at any time, you wish you stop receiving our emails, you may conveniently unsubscribe.**

Thank you for your consideration of this request.

Full Name \_\_\_\_\_

Email Address \_\_\_\_\_

# Patient History Form

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Date: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_ Physician: \_\_\_\_\_

When did your problem first occur (date) \_\_\_\_\_ Date of Surgery \_\_\_\_\_

How did your problem first start?  
\_\_\_\_\_

Please describe your symptoms including intensity, location and frequency.  
\_\_\_\_\_

Is your pain worse in the morning, as the day progresses, or at the end of the day?  
\_\_\_\_\_

What increases your symptoms? \_\_\_\_\_

What decreases your symptoms? \_\_\_\_\_

Is your pain constant or intermittent? \_\_\_\_\_

**Pain Scale:** please mark on the line the best intensity of your pain right now

No pain |-----|-----|-----|-----|-----|-----| Severe pain

If 0 is "no pain" and 10 is the worst imaginable pain, my pain currently is a \_\_\_\_\_

Have you had treatment for this problem before? \_\_\_\_\_ By whom? \_\_\_\_\_

Please check any of the following medical conditions that apply to you:

Allergies		Osteoporosis	
Cancer		Pacemaker	
Congestive Heart Failure		Pregnant	
Diabetes		Pulmonary conditions	
Heart Conditions		Rheumatoid Arthritis	
Hiatal Hernia		Seizures	
High Blood Pressure		Stroke (CVA)	
Osteoarthritis		Other _____	

Medications \_\_\_\_\_

Have you had x-rays, MRI, or other tests for your current problem?

Please explain \_\_\_\_\_

My general health is (circle one) excellent/good/fair/poor.

Prior to injury, my activity level was good/fair/poor.

My current activity level is good/fair/poor

Occupation: \_\_\_\_\_

Are you currently working? \_\_\_\_\_ Last day worked: \_\_\_\_\_

Job activities/Requirements \_\_\_\_\_  
\_\_\_\_\_

Is light duty available: \_\_\_\_\_?

Hobbies: \_\_\_\_\_

What are you unable to do now that you want or need to be able to do?  
\_\_\_\_\_

What are your goals for therapy \_\_\_\_\_?

In what time frame would you like to see the above goals achieved? \_\_\_\_\_

\*Do you have any physical reason why you would not be able to negotiate our facility both indoors and out without direct supervision from a family member or employee? If yes, please describe.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_