



Professional Sports & Orthopaedic Rehabilitation Associates, LLC

Game Shape
455 Route 9 South
Manalapan, New Jersey 07726
(732) 617 - 8090
Fax: (732) 972 - 5458

PAST MEDICAL HISTORY FORM

PATIENT INFORMATION:

Patient Name: Date:
Age: Date of Birth: Marital Status:
Children (Ages): Spouse's Name:

Occupation: Employer:
Working: Full Duty Light Duty Part Time None
Physical Work: Heavy: Moderate: Light: Hours per day:
Job Requirements:

Date of next MD Visit:

Completed which Special Tests: X-Ray CAT Scan MRI EMG Other
Results or Findings:

Current Height: Current Weight: Lost or Gained Weight?

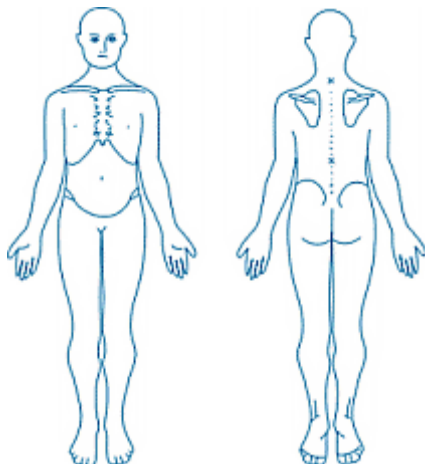
- 1. Date of Injury / Onset:
2. What are your major complaints?
3. Have you ever experienced these symptoms before? No Yes Explain:
4. Check which apply to your symptoms: Work Related Injury Motor Vehicle Accident
Reoccurrence of Previous Injury Injury Related to Lifting Athletic / Recreational Injury
Related to Disease Congenital Abnormality Cause Unknown
5. Have you had a related surgery? No Yes Explain:
6. Do you have, or have you had any of the following:

Table with 2 columns of medical conditions and 'No'/'Yes' response options. Conditions include Diabetes, Rheumatoid Arthritis, Osteoporosis, Allergies, Scoliosis, Joint Disease, Previous Fractures, Jaw / TMJ Problems, Nerve Injury, Thyroid Problems, Epilepsy or Seizures, Cancer, COPD, Emphysema, Asthma, Shortness of Breath, Concussion, Multiple Sclerosis, Ringing in Ears, Sexual Dysfunction, and Metal Implants.

If "yes" on any of the above, please briefly explain and give approximate dates:

7. Is there a possibility you are pregnant? No _____ Yes _____
8. Do you smoke? No _____ Yes _____ If yes, packs per day: _____
9. Do you drink alcohol? No _____ Yes _____ If yes, explain: _____
10. Do you have special diet guidelines? No _____ Yes _____ If yes, explain: _____
11. Is there any other information regarding your past medical history that your therapist should know about?
Please explain: _____
12. Are you presently taking any medication? No _____ Yes _____ Please list dosage, frequency, and reason for use: _____

13. Please indicate below where you pain is located.



Aches	x x x x x
Numbness	//////
Pins / Needles	⚡
Stabbing	✦
Referred Pain	→

Mark an "X" on the lines:

How bad are your symptoms now? _____
None Most Severe

How bad have they been in the past? _____
None Most Severe

14. Rate the intensity of your pain on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain.

Now: _____ Worst in past 24 hours: _____ Best in past 24 hours: _____

15. Do you participate in any sports, exercise programs, or activities on a regular basis? No _____ Yes _____
If yes, explain: _____

16. Do any positions or activities make you feel worse? Explain: _____

17. Do any positions or activities make you feel better? Explain: _____

18. Is this condition: Improving _____ Unchanged _____ Getting Worse _____

19. Is this condition interfering with your: Work _____ Sleep _____ Daily Routine _____ Play _____

20. What do you think caused this condition? _____

21. In the rare instance of an emergency, who should we contact?

Name: _____ Phone: _____

Patient Name: _____ Date: _____

Reviewed by Physical Therapist: _____ Date: _____



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CONSENT TO TREATMENT

I understand that I have been referred for rehabilitative treatment and care to Professional Sports & Orthopaedic Rehabilitation Associates, LLC. A therapist representing Professional Sports & Orthopaedic Rehabilitation Associates, LLC will described for me my individual treatment plan. I understand that I have the right to ask and have my questions answered prior to receiving treatment. By signing this agreement, I consent to have Professional Sports & Orthopaedic Rehabilitation Associates, LLC provide assessment, treatment and care as prescribed by my physician and/ or recommended by my therapist. I further authorize Professional Sports & Orthopaedic Rehabilitation Associates, LLC to release, to appropriate agencies, any information relating to all claims for benefits submitted on behalf of myself and/or my dependents.

Patient Signature: _____ Date: _____

Witness (w/ relationship to patient): _____

In Case of Emergency: _____ Phone: _____



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INSURANCE COVERAGE

Professional Sports & Orthopaedic Rehabilitation Associates, LLC appreciates the confidence you have shown in choosing us to provide for your rehabilitative needs. At Professional Sports & Orthopaedic Rehabilitation Associates, LLC, "service" is our business. We are committed to serving you with skill, knowledge and care. We consider health care to be a team effort between the patient, the physician, and us. It is a service that you have elected to participate in, which implies a financial responsibility on your part to Professional Sports & Orthopaedic Rehabilitation Associates, LLC. It is a responsibility that requires you to ensure payment in full of our fees.

It is our goal to provide our patients with the best quality of rehabilitative care at a reasonable cost, while still providing full service, such as billing directly to your insurance carrier on your behalf. In today's health care marketplace, coverage for physical therapy varies greatly with the type of insurance you have. Many insurance companies require pre-certification for physical therapy. Prior to your first visit we will call your insurance company to ascertain your particular insurance coverage and/or requirements. We will advise you of this information before you start therapy and we will make every effort to comply with your insurance company's requirements to ensure proper coverage.

For your benefit, an explanation of insurance coverage is provided below. We participate with most insurance plans.

Costs to expect if you are using:

Workman's Compensation as your coverage:

If you were injured at work and filed a claim with your employer, your employer's workman's compensation insurance company will pay the entire amount of your care and we will bill them directly for your physical therapy. All workman's compensation plans are accepted by Professional Sports & Orthopaedic Rehabilitation Associates, LLC with employer authorization.

Automobile - Personal Injury Protection (PIP) as your primary coverage:

Every NJ auto policy has a deductible and a co-payment amount. Beyond that, we will bill your insurance company directly and wait for their payment. For example, a typical policy may have a \$250 deductible and a 20% co-payment for the first \$5,000 of care. Therefore you would be responsible for all of the first \$250, and 20% of the next \$5,000. After that, most are covered 100% to the maximum coverage of your policy (usually \$250,000). When purchasing your auto policy you may have selected this arrangement or different coverage amounts. Check your policy or call your insurance agent for the details of your coverage and call us if you have any questions. All auto plans are accepted by Professional Sports & Orthopaedic Rehabilitation Associates, LLC.

Additionally, if you so elected when purchasing your auto insurance coverage, your health insurance or Medicare policy may act as a secondary insurer and pay your deductible and co-payment amounts. Again, check your policy or call your insurance agent for details of your coverage and call us if you have any other questions.

Medicare as your primary coverage:

We are participating providers with Medicare and will bill Medicare directly for you. You are responsible for the Part B deductible and the 20% co-payment. Professional Sports & Orthopaedic Rehabilitation Associates, LLC agrees to accept the Medicare fee schedule and wait for payment. If you have a secondary insurance (Medicare supplement or other indemnity plan), we will bill them for the 20% and wait for their payment. If not, you are responsible for the 20% co-payment.

Traditional Health Insurance as your primary coverage:

Expect to pay any remaining amount of your annual deductible and the amount of your co-payment (often 20%). The rest, we will bill to your insurance company and wait for their payment directly to us. If you have a secondary private insurance plan available through the coverage of your spouse, Professional Sports & Orthopaedic Rehabilitation Associates, LLC is usually able to bill that insurance for the co-payment amount.

HMO/POS Health Insurance as your primary coverage:

Feel free to call us and/or your insurance representative to find out if we participate with your insurance plan. In addition, we will verify your specific coverage. You are responsible only for your daily co-payment amount. When receiving care within your network, you will need an approval or authorization from your primary doctor before seeing us. The difference between HMO and POS plans is that HMO plans always require you to stay within a network of providers. POS plans have a network as well, but also permit you to receive care out of the network - usually with higher co-payments.

_____ PPO Health Insurance as your primary coverage:

Almost all PPO plans allow you to be seen anywhere you prefer. What varies is your out of pocket expense. Feel free to call us and/or your insurance representative to find out if we are “in-network” with your insurance plan. In addition, we will verify your specific coverage. If Professional Sports & Orthopaedic Rehabilitation Associates, LLC is an in-network provider you are responsible only for in-network co-payments and any deductible listed on your insurance card. If we are not a participating provider, you are responsible for out-of-network co-payments and deductibles listed on your insurance card. Please feel free to call us for advise regarding details of coverage for your situation.

_____ No Insurance Coverage / Self-Pay Option:

In this case, there is no insurance coverage available for you to receive services rendered at Professional Sports & Orthopaedic Rehabilitation Associates, LLC. Therefore, you agree to self-pay at the rates determined and outlined to you by Professional Sports & Orthopaedic Rehabilitation Associates, LLC.

We are listed in “provider handbooks” under the name of either:

- 1) Professional Sports & Orthopaedic Rehabilitation Associates, LLC**
- 2) Michelle E. Wolpov, PT, ATC, CSCS, MBA License #: QAO3911**

I have read the above policy regarding my financial responsibility to Professional Sports & Orthopaedic Rehabilitation Associates, LLC for providing rehabilitative services to me or the individual named below. I agree to pay Professional Sports & Orthopaedic Rehabilitation Associates, LLC the full and entire amount of all bills incurred by me or the individual named below; or any amount due after payment has been made by my insurance carrier.

I understand that it is my full responsibility to inform Professional Sports & Orthopaedic Rehabilitation Associates, LLC of any correspondence that I receive from my insurance company notifying me of a change or cessation of payment of physical therapy bills.

Physical therapy benefits are quoted to Professional Sports & Orthopaedic Rehabilitation Associates, LLC by my insurance carrier. These benefits are subject to the terms and conditions of my plan and are NOT necessarily a guarantee of payment.

In addition,

- I authorize my insurance company to pay benefits directly to Professional Sports & Orthopaedic Rehabilitation Associates, LLC.**
- I am financially responsible for any non-covered services provided by Professional Sports & Orthopaedic Rehabilitation Associates, LLC.**
- I authorize Professional Sports & Orthopaedic Rehabilitation Associates, LLC to release medical information required for billing purposes.**
- I understand that the bill for any scheduled physical therapy appointments not cancelled at least 24 hours prior, excluding any personal emergencies or situations approved by my treating therapist, shall be paid for by me.**

Patient Signature (or Parent if patient is a minor): _____ Date: _____

Insured Signature (if different from above): _____ Date: _____

Witness: _____

My insurance has been explained to me:

Initials: _____ Date: _____



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FOR OFFICE USE ONLY:

Patient Code: _____

Information taken by: _____ Date: _____ Time: _____ Office: _____

Appointment for Initial Evaluation: Date: _____ Time: _____ Therapist: _____

PATIENT INTAKE FORM

PATIENT INFORMATION:

Patient Name: _____ Marital Status: _____

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-Mail: _____

Date of Birth: _____ Social Security No.: _____

Employer: _____ Phone: _____

Diagnosis: _____ DOI / DOO: _____

Referred by: Newspaper _____ Yellow Pages _____ Brochure _____ Hospital _____ Friend _____

Radio _____ Direct Mail _____ Physician _____ Insurance Co. _____ Member _____

Referral Source Name: _____

Address: _____ Phone: _____

PCP Name (If different): _____

Address: _____ Phone: _____

INSURED'S INFORMATION:

Name of Responsible Party: _____

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-Mail: _____

Date of Birth: _____ Social Security No.: _____

Employer: _____ Phone: _____

PRIMARY INSURANCE:

Claim Made Under: WC _____ MVA _____ Medicare _____ Commercial _____ Legal _____ Other _____

Insurance Co: _____ Phone: _____

Address: _____

Claim Rep Name: _____ Phone: _____

Policy / ID No.: _____ Group No.: _____

Claim No. (If WC / MVA): _____ Case Manager / Phone: _____

SECONDARY INSURANCE:

Insurance Co: _____ Phone: _____

Address: _____

Claim Rep Name: _____ Phone: _____

Policy / ID No.: _____ Group No.: _____

Claim No. (If WC / MVA): _____ Case Manager / Phone: _____

**Professional Sports & Orthopaedic Rehabilitation Associates, LLC
Consent Agreement**

**Consent to the Use and/or Disclosure of Health Information for
Treatment, Payment or Healthcare Operations.**

I _____, understand that as part of my treatment and care, this office creates and maintains health records describing my medical history, symptoms, examination and test results, diagnoses, treatment and any plans for future care and/or treatment. I understand that this information serves as:

1. A basis for planning my care and treatment.
2. A means of communication among the many healthcare professionals who contribute to my care.
3. A source of information for applying my diagnosis and treatment information to my bill.
4. A means by which a third-party payer can verify that services billed were actually provided.
5. A tool for routine healthcare operations such as assessing quality and reviewing the competence of our staff.

I understand if I wish to obtain a copy of the Office's Notice of Privacy Practices, that provides a more complete description of information uses and/or disclosures, one will be made available for me. I understand that I have the right to review the Notice prior to signing this consent. I understand that this Office reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised Notice of the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that this Office is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except that for actions taken by this Office in relying on such information.

I understand and authorize, that at times it will be necessary for this Office to call my home or place of business and leave messages on an answering machine, voice mail or E-mail.

I authorize this Office to send newsletters and other information to keep me informed about changes in services, clinical news and updates, and special offers.

I fully understand and accept decline the terms of this consent.

Patient's Signature

Date

NEWSLETTER OPT-IN AGREEMENT

Thank you for choosing Game Shape – Physical Therapy & Sports Performance Center. We have created a unique newsletter for you. Each month you will be provided valuable information about services, injury prevention & rehabilitation and the latest on fitness and personal training.

We will include information about special programs, giveaways and downloads. Learn about treatments, medical conditions, sports training, fitness, training techniques and more.

Information: **Please Print Clearly!**

Name: _____

E-Mail Address: _____

By submitting this information, I confirm that I am only acting for my own e-mail account, or one for which I have express authority to submit this request. Once the subscription is confirmed, I agree to accept newsletter e-mails from Game Shape – Physical Therapy & Sports Performance Center and my e-mail address will not be used for any other purpose. I understand that I may unsubscribe at any time by following your instructions and that I may still receive a limited number of e-mails while this request is processed.

Signature: _____

**GAME SHAPE – PHYSICAL THERAPY & SPORTS PERFORMANCE CENTER
WILL NOT SHARE, DISTRIBUTE, OR SELL YOUR E-MAIL ADDRESS.**





455 Route 9 South
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Physical Therapy: (732) 617 -8090
Fax: (732) 972 -5458

www.GameShapeOnline.com

NO SHOW POLICY

I understand that I will be charged a \$25.00 fee if I fail to keep an appointment without calling to cancel or reschedule; or if I need to be called because I have not shown up for my appointment time. This missed visit will be considered a “No Show” and the \$25.00 no show fee will be my responsibility. My insurance will not be billed.

Patient Signature _____

Date _____

Physical Therapy provided by



Professional Sports & Orthopaedic Rehabilitation Associates, LLC

Michelle E. Wolpov, PT, MBA, ATC, CSCS
Owner / Director License #QAO3911