MVA

M.J. Scott D.O. & Associates, PA

Last Name: ____________________ First Name: ______________________ SEX: M F
If patient is a minor, name of parent or guardian accompanying patient: ______________________
Relationship to patient: __________________ Phone # (if different): ______________________
Address: ____
City: ______________________ State: _______________ Zip Code: __________________
Home #: ______________ 2nd Phone: _______________ Email: ____________________
Date of Birth: _________ SS#: _______________ married single divorced widowed (circle one)
Referred by: _____________________ Phone: ________________ Location: ____________
Family Doctor: ____________________ Phone: ________________ Location: ____________
Date of accident: (If applicable): _______________ **Type of accident:** __________________
Please briefly describe the accident. If necessary, you may use the back of this page. Please also note whether you were in the course of employment at the time.

____

Primary Insurance Name: __________________________ Auto Health WC (circle one)
Phone #: ____________________ Adj.: ____________________ Ext.: ________________
Claim or ID #: ___________________________________ Group #: _________________
Subscriber: ____________________________________ Relationship: _______________
Subscriber Date of Birth: ______________ Subscriber Social Security #: _______________
Secondary Insurance Name: ________________________ Auto Health WC (circle one)
Phone #: ____________________ Adj.: ____________________ Ext.: ________________
Claim or ID #: ___________________________________ Group #: _________________
Subscriber: ____________________________ Relationship: ________________________
Subscriber Date of Birth: ______________ Subscriber Social Security #: _______________
Attorney Name: _________________________ Firm: ___________________________
Location: _________________________________ Phone: __________________________
Employer Name : __________________________ Phone: _______________________
Emergency Contact: __________________________ **Phone:** _____________________
Are we authorized to release your medical information to the listed emergency contact? Yes or No (circle)

ACKNOWLEDGEMENT AND UNDERSTANDING

Medical Release – I hereby request and authorize Martin J Scott D.O., to disclose, make available and furnish to:
Company Name: ____________________________
Or his/her authorized representatives all information, records, xrays, reports or copies related to my examination, consultation or treatment and do permit him/her to inspect and make copies or abstracts thereof. I release the doctors, therapists, agents, employee's and any personnel acting on behalf of this office from any and all liability whatsoever pertaining to any use of these records. A photocopy of this form will be valid as the original form
Patient Signature: ______________________________ Date: ____________________

Records Release – I hereby authorize the release of my records/x-rays/reports or copies of such and request that they be transferred or made available to Martin J. Scott, D.O.
Patient Signature: ______________________________ Date: ____________________

Consent to Treatment of Minor – I hereby authorize Martin J. Scott, D.O., to render healthcare to my son/daughter as deemed necessary by the physician.
Patient Signature: ______________________________ Date: ____________________

Authorization for Release of Information

Name of Patient________________________ Date of Birth ____________

Martin J Scott is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information Check each person/entity that you approve to receive information.	**Description of information to be released** Check each that can be given to person/entity on the left in the same section.
° Voice Mail	° Results of lab tests/x-rays Other: ____________________ ____________________
° Spouse (provide name & phone number) ____________________ ____________________	° Financial ° Medical as follows: ____________ ____________________
° Parent (provide name & phone number) ____________________ ____________________	° Financial ° Medical as follows: ____________ ____________________
° Other (provide name & phone number) ____________________ ____________________	° Financial ° Medical as follows: ____________ ____________________

______________________________ ____________

Signature of Patient or Personal Representative Date

______________________________ ____________

Signature of Witness Date

2312 Whitehorse-Mercerville Road • Cranbrook Bldg • Suite 102 • Mercerville, NJ 08619
Phone (609) 890-6363 Fax (609) 588-5225 • email: drmjscott.office@gmail.com
Managed Occupational, Pain and Family Medicine
Board Certified

CONDITIONAL ASSIGNMENT OF BENEFITS

Policy Number: ______________________ **Claim Number:** ________________

Patient's Name: ____

Medical Provider/s Name: **Martin J. Scott, D. O.**

I authorize and request ________________________ to pay directly to the above-named medical provider, the amount due to me under the terms of the above- referenced policy as a result of medical care needed by that medical provider and all medical staff associated with the provider's office.

______________________________________ ____________________

Patient's Signature or Parent/Legal Guardian *Date*

______________________________________ ____________________

Provider's Signature *Date*

Martin J. Scott, D. O.

Provider's Name (Print)

TIN Number: **22-2617425**

Address: **2312 Whitehorse-Mercerville Road, Suite 102**
Mercerville, NJ 08619

IRREVOCABLE ASSIGNMENT OF BENEFITS/ LETTER OF PROTECTION / LIEN

I/ ME/ MY, ______________________________________, the insured and/or beneficiary of the policy of ________________________ insurance providing medical benefits to me, do hereby authorize you, Martin J Scott, medical benefits due to me under the terms of the applicable policy(s) issued by our company(s). Payment is authorized upon receipt of the itemized statement for services rendered. This insurance policy was in full force and effect at the time services were rendered. Payment, in whole or in part, shall be considered the same as if paid by your company directly to me, the insured. A photocopy of this assignment shall be valid as the original.

I authorize Martin J Scott to obtain legal counsel by and through any law firm of their choosing and to enter into legal (PIP Arbitration) or other action to collect such sums due it, should sums not be paid within the legally prescribed time period. I do herby promise full and complete cooperation with Martin J Scott's legal counsel, including attending any type of medical examination (IME), deposition, arbitration, or court proceeding. I understand that should I fail to cooperate with the legal counsel, I may be held personally responsible to Martin J Scott for any expense not covered by this assignment/ letter of protection (hereinafter referred to as an "LOP") and/or expenses not recovered due to my failure to cooperate.

Authorization to Release Medical Records

The undersigned hereby consents and authorizes the release of any and all medical records, reports, films, etc. directly to Martin J Scott and/or their designated legal counsel, directly from ____________________ or any and all hospitals, diagnostic facilities, or physicians that have rendered medical treatment, diagnostic testing, or any type of medical services to the undersigned as a patient.

Authorization to Release Information

__________________________ is hereby authorized to release to Martin J Scott and/or their designated legal counsel all or any part of my medical record, billing information, insurance policy information, EOBs, and any information contained in my PIP file.

Financial Responsibility

I hereby agree and acknowledge that I may receive benefit checks directly from the insurance carrier for services rendered by Martin J Scott. I hereby agree to immediately forward said check(s) to Martin J Scott upon receipt of same. It is understood and agreed that should I receive benefit checks and fail to forward any benefit checks to Martin J Scott, Martin J Scott does maintain the right to request checks from me and initiate any and all collections efforts against me. If such action is taken by Martin J Scott, I agree to be responsible for any and all benefit checks received plus any and all reasonable collection cost incurred including, but not limited to, attorney fees, interest, expert fees, and court costs.

Letter of Protection / Attorney Directive / Irrevocable Assignment

I hereby irrevocable authorize my attorney ______________________, Esquire to pay directly to Martin J Scott sums as may be due and owing for services rendered by Martin J Scott, and to withhold such sums from any bodily injury policies, disability, medical payment benefits, no-fault benefits, health and accident benefits, workers' compensation benefits, or any other insurance benefits obtained to reimburse the undersigned, or from any settlement, verdict or judgment which may be paid to me or my attorney as a result of the injury or illness for which I have received service from Martin J Scott.

I irrevocable assign to Martin J Scott all rights and benefits under my insurance contracts for the payment of services rendered by Martin J Scott. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by Martin J Scott to be released to Martin J Scott and/or their legal counsel. I irrevocable authorize Martin J Scott to file insurance claims on my behalf for services rendered to me. I irrevocable direct that all such payments go directly to Martin J Scott. I irrevocable authorize the above medical provider, and/or their legal counsel, to be present at all legal proceedings with regard to my Personal Injury Protection (PIP) benefit, including but not limited to Examinations Under Oath (EUO), depositions, whether there is pending litigation or not (e.g. Arbitrations or Court Proceedings).

DATE: ________________ PATIENT'S SIGNATURE: ____

The undersigned, being the attorney of record for the above patient, does hereby agree to observe all terms of the above and agree to withhold such sums from any settlement, verdict, or judgment as may be necessary to fully protect Martin J Scott's rights to be compensated for services rendered and related to the above-captioned claim/case. This agreement is irrevocable.

DATE: ________________ ATTORNEY'S SIGNATURE: ____

Note: Attorney, kindly sign and date one copy and return as soon as possible to the address listed above as an acknowledgement of this document.

Personal Information

Please answer each question with your best judgment.
This will ensure the most accurate course of treatment for your injuries.

Start date of symptoms: ______________________________

Possible cause of symptoms: ______________________________

Are you pregnant? Y / N **Do you have a Pacemaker? Y / N**

Have you received any other treatment? ☐ No ☐ Yes

☐ PT: ____________________ ☐ Chiropractor: ____________________

☐ Trigger Point Injections by: ____________________ ☐ Neurologist: ____________________

☐ Orthopedic Surgeon: ____________________ ☐ Surgery: ____________________

☐ Other: ______________________________

When did this treatment occur? : ______________________________

What was treated? (ex: lower back, right shoulder…):

____

Result from treatment? (ex: worsened, remained same, improved, cured…):

____

CURRENT PAIN?

- **NECK: Pain level (0-10) 0 1 2 3 4 5 6 7 8 9 10**
- **MIDBACK: Pain level (0-10) 0 1 2 3 4 5 6 7 8 9 10**
- **LOWER BACK: Pain level (0-10) 0 1 2 3 4 5 6 7 8 9 10**
- **HEADACHE: Pain level (0-10) 0 1 2 3 4 5 6 7 8 9 10**
- **Other Location ____________________: 0 1 2 3 4 5 6 7 8 9 10**

- **Other Location ____________________: 0 1 2 3 4 5 6 7 8 9 10**
- **Does the pain radiate anywhere? ("shooting down to the left or right arm" or "shooting up to the head")**

  ____

  ____

- **Please, describe your pain** ☐ Dull ☐ Aching ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Throbbing ☐ Numbness ☐ Burning
- **How often is your pain present?** ☐ Occasional ☐ Frequent ☐ Constant
- **Worst time of day?** ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ All the time
- **Numbness anywhere?** ______________________________
- **"Pins and needles" or tingling sensation anywhere?** ____________________
- **Weakness? (Right leg, right arm, both legs...)**

  ____

- **Swelling?** ____
- **What makes symptoms worse/exacerbate?**
  ☐ Walking ☐ Standing ☐ Lying down ☐ Sitting ☐ Bending forward ☐ Bending backward ☐ Driving ☐ Coughing
  ☐ Bowel movement ☐ Cold weather ☐ Hot weather ☐ Rainy day ☐ Lifting objects
- **What makes the symptoms better?**
  ☐ Resting ☐ Massage ☐ Exercise ☐ Sitting ☐ Lying down ☐ TENS unit ☐ Physical therapy ☐ Chiropractic treatment
  ☐ Sleeping ☐ "Injections" ☐ Medication (Names): ____________________ ☐ Other: ____________________
- Sleeping: ☐ Well ☐ "OK" ☐ Terrible ☐ 2 hrs ☐ 4 hrs ☐ 6 hrs ☐ 8 hrs ☐ > 10 hrs
- How often do you wake up at night due to pain? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ >5 times

Do you have any of the following today? (Check all that apply)

☐ AIDS/HIV	☐ Anemia	☐ Angina	☐ Arteriosclerosis
☐ Arthritis	☐ Asthma	☐ Blood Clots	☐ Bone Infection
☐ Cancer	☐ Chemical Dependency	☐ Circulation Problems	☐ Depression
☐ Diabetes	☐ Epilepsy	☐ Eye Infection	☐ Heart Problems
☐ Hemophilia	☐ High/Low Blood Pressure	☐ Joint/Bone Injection	☐ Liver Problems
☐ Lung Issues	☐ Multiple Sclerosis	☐ Musculoskeletal Problems	☐ Pneumonia
☐ Stroke	☐ STD	☐ Tuberculosis	☐ Urinary Infection

Pride Physical Therapy

CONSENT TO TREAT

The patient has the right to informed participation is decisions involving his/her health care. This shall be based on clear, concise explanation of his/her condition and of all proposed treatment procedures. All possible risks and/or side effects, as well as the probability of success with such procedures shall be disclosed to the patient by his/her attending physical therapist. The patient shall not be subjected to any procedure without his/her voluntary, competent and understanding consent or consent of his/her legally authorized representative. Where medically significant alternatives for care or treatment exist, the patient shall be so informed. After reading the above, I ________________________________, hereby consent to receive physical therapy treatment at Pride Physical Therapy/ Steve Demkowicz, DPT, commencing on ____________________(Date) and terminating when determined by myself, my physician, or my physical therapist. I have read this information and understand its content.

*Patient Signature:*______________________________ *Date:* ________________

AUTHORIZATION TO RELEASE/RECEIVE INFORMATION

I give my consent to PRIDE PHYSICAL THERAPY, to disclose health information to my insurance carrier for the purpose of billing, to my physician or other healthcare professionals involved in my care, or receive health information from other healthcare professionals as it relates to my treatment, as permitted/required by law. I understand that confidentiality of my health information is protected under state and federal law, and that this release gives consent to PRIDE PHYSICAL THERAPY only, and not to any party to whom such information is released.

Patient Signature: ______________________________ *Date:* ________________

PATIENT PAYMENT POLICY

The fee schedule of PRIDE PHYSICAL THERAPY, is based on usual and customary fees for the type of services provided. Generally, your insurance policy will cover some portion, if not all, of the payment for services provided. There is, however, no guarantee of payment. The balance amount that your insurance carrier does not cover will be your responsibility. You are also responsible for any deductible and co-pay. We request that any insurance payments that are sent directly to you be presented promptly to PRIDE PHYSCIAL THERAPY, along with the explanation of benefits and/or any other information you received with the payment. You are directly responsible for payment of medical supplies. Statements will be sent to you if you have an outstanding patient balance. Payment for your portion of services is requested to be paid within fifteen (15) days of receipt of the statement. I attest that my insurance coverage and personal financial responsibilities regarding physical therapy treatments have been fully explained to me. **Any missed appointment or late cancellation will result in a $60.00 charge. To avoid these fees please cancel appointments the day before, no later than 4pm (late night phone messages WILL NOT be acceptable for appointments before10:30AM)**

Patient Signature: ______________________________ *Date:* ________________

MEDICARE PATIENTS ONLY

I request that payment of authorized Medicare benefits be made to me or on my behalf to the practitioner named above. I authorize any holder or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. I have read this information and understand its content.

Patient Signature: ______________________________ *Date:* ________________