Personal Physical Therapy

Date: _____

Patient Registration

Patient Information

First Name _____ Last Name _____ Middle _____

Address _____

City, State Zip _____

Phone: Please check (☒) which number you prefer to be your primary contact:

☐ Home _____ ☐ Mobile _____ ☐ Work _____

Birth Date _____ **EMAIL**: _____

Marital Status: Married ☐ Single ☐ Other ☐ Social Security Number: _____

Gender: Male ☐ Female ☐ Employment Status: Employed ☐ Retired ☐ Student ☐ Military ☐

Employer Name: _____

Address & Phone: _____

_____

Emergency Contact

Name _____ Relationship _____

Phone Number _____

Physician Information

Referring Physician (first/last name) _____ Phone: _____

Primary Doctor (first/last name)_____ Phone: _____

Primary Insurance

Insurance:_____

Name of **Subscriber**: _____

Relationship to patient: _____

Subscriber's Birthday _____

Group Number _____

Insurance ID/Member # _____

Subscriber's Employer: _____

Subscriber's Work Address: _____

_____

Subscriber's Work Phone: _____

Secondary Insurance

Insurance: _____

Name of Subscriber: _____

Relationship to patient: _____

Subscriber's Birthday _____

Group Number _____

Insurance ID/Member # _____

Injury Information

Injury Area: _____

_____

Injury Related to: Employment ☐ Auto ☐ N/A ☐

CONSENT TO TREAT

MYSELF

I hereby authorize the professional staff at Personal Physical Therapy to examine and treat me with physical therapy for the injury I have been referred here for or have referred myself here for.

Patient Signature:_____ Date: _____

My Child

I hereby authorize the professional staff at Personal Physical Therapy to examine and treat my child with physical therapy for the injury he/she been referred here for.

Parent / Guardian Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers, or as a result of a liability or worker's compensation claim.
- Conduct normal healthcare operations such as quality assessments and service improvements.

By signing below, I acknowledge that I have been offered/received a copy of Personal Physical Therapy's Notice of Privacy Practice document.

Patient Name: _____D.O.B. _____

Signature: _____DATE: _____

Relationship to Patient: _____

Please list below the names, relationships, and phone numbers of any authorized individuals with whom we may discuss your medical or financial information. This permission will extend to making and verifying appointments, billing information, and general care with either the office staff and/or providers.

NAME RELATIONSHIP PHONE

_____

_____

_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:Refused	Communication Barrier	Emergency	Other

PERSONAL HISTORY

Patient Name _____ Age _____

Have you had any physical therapy this year of any type? Yes _____ No _____
When: _____ Where? _____
Approximately how many treatments? _____

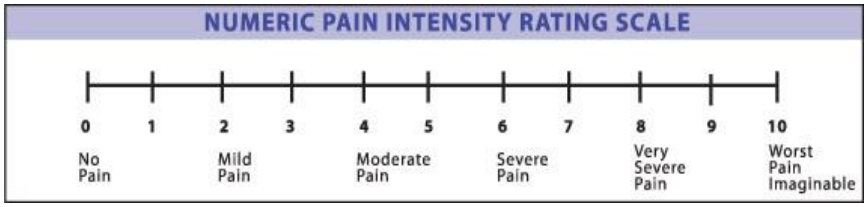
Have you had any **home care services** of any type this year? Yes _____ No _____
If so, what type? (Nursing, PT, OT, Home Health aide, etc) _____
Have all of these services ended? When? Date: _____

RISK/BALANCE Assessment: Have you fallen in the past 12 months? Yes _____ No _____

In the past, have you had….:

Yes	No			
_____	_____	Fractures/Broken Bones	What area _____	When _____
_____	_____	Sprains/Strains	What area _____	When _____
_____	_____	Surgeries	What area _____	When _____
_____	_____	Medical conditions/ or major illness	Please specify: _____	

Current Pain Assessment
Please circle appropriate pain level number



Please provide a list of **all** medications you are currently taking. _____
_____

Any personal history of Hypertension/Diabetes/Cancer? Explain _____
_____

Are you pregnant? ___ yes ___ no

Other important information _____
_____

Are you currently working? ___ yes ___ no If no, is it because of this injury? ___ yes ___ no

Have you had an injury to this area before? ___ yes ___ no If yes, explain _____
_____
_____

What is your occupation and specific need of your job that you need help with? _____
_____

Do you participate in any hobbies or athletics that you have difficulty doing or would like to return to? If so, what are they? _____

Name all physicians, chiropractors, specialists, physical therapists, etc. you have seen in regards to this injury:
_____
_____ _____ _____

Have you had any of the following in regards to this injury: (Circle all that apply)
Cat-Scan MRI Bone Scan X-Rays Other _____

To All Our Medicare Patients

Your Medicare insurance takes your health very seriously. They have now mandated that all health care providers report on key aspects of your health. In Physical Therapy, we are mandated to report on the following:

Patient Name _____

Please list your current medications, including dosage:

_____

_____

_____

_____

_____

_____

_____

_____

Height _____ Weight _____

Have your fallen in the past year? If so, how many times?

_____

_____

Have you had any physical therapy this year of any type?

_____

_____

Please let us know if you have had a functional decline:

_____

_____

Do you have pain? If so, where?

_____

_____

_____ _____

Patient / Guardian Signature Date

No Show/Late Cancellation Policy

This policy has been established to help us serve you better.

We strive to provide our patients with excellent service and quality care. Our commitment to your well-being and health care is something that we at Personal Physical Therapy take very seriously. Your commitment to your physical therapy program is critical to your success. We will recommend treatment and set goals with you. In order to reach those goals you must do your part, and your most important part is to make each and every appointment.

A 'No Show is missing a scheduled appointment without cancelling first. A 'late cancellation' is canceling an appointment without calling us to cancel 24 hours in advance.

We understand that situations as medical emergencies occasionally arise when an appointment cannot be kept and adequate notice is not possible. These situations will be considered on a case by-case basis.

A charge of $25.00 will be charged for each late cancellation if less than 24-hours notice is given.

A charge of $50 will be charged for each no show.

Repeated cancellations/no-shows may result in removal from our schedule.

Please understand that insurance companies consider this charge to be entirely the patient's responsibility.

To cancel appointments, please call 508-481-5519. Please do NOT text or email. If you do not reach the receptionist you may leave a detailed message on the voice mail. If you would like to reschedule your appointment, please leave your phone number. We will return your call and give you the next available appointment time.

If you 'No-Show' for an appointment, you will have **24 hours to contact us** to confirm your next appointment. If we do not hear from you within that time, **your remaining appointments will be cancelled**.

We thank you for choosing ***Personal Physical Therapy.*** We look forward to working with you and helping you reach your goals.

The Staff at Personal Physical Therapy

I have read and understand this policy:

_____ _____

Patient / Guardian Signature Date

Our Financial Policy
Regarding Insurance Deductibles

What is an insurance deductible? The **deductible** refers to the amount of money that the insured (the person covered by a health insurance policy) must pay out-of-pocket before the insurance company will pay any expenses. This is usually an annual amount so when the policy renews, usually after a year, the deductible would reset to its full amount. Some services, like doctor visits, may be available without meeting the deductible first. Usually there are separate deductible amounts for each individual covered in the policy, as well as total family deductible amounts.

Most insurance policies now have large deductibles. Insurance companies will not begin to pay for your therapy visits until you have paid your entire deductible. You are responsible for the entire dollar amount of your deductible.

As a courtesy, our Staff strives hard to educate our patients on their insurance requirements and any dollar amount remaining on their deductible. Deductibles are annual and their amount may change from year to year. Ultimately, you are responsible for any dollar amount of your deductible that has not been met. *Personal Physical Therapy* does not receive any reimbursement from your insurance until you meet your deductible. We bill the insurance directly and receive statements showing what we need to collect from you for your visit(s).

If you have a deductible and it has not been met, *Personal Physical Therapy* offers two options of payment:

1. You can leave a credit card on file and we will charge your credit card when the insurance statements come in. We will then mail you a receipt along with a copy of the insurance statement.

OR

2. You can pay at the time of service. We will still bill your insurance so you receive credit toward your deductible. The cost of a first visit is $100. The cost of therapy after the first visit will be the cost of the contracted rate of your particular insurance, or $70 if you are not going through insurance.

_____ _____

Patient / Guardian Signature Patient /Guardian Name (Printed)

_____

Date