Massabesic Health Resources, P.A.
Orthopedic Manual Physical Therapy, Sports, & Wellness

GREATER SPRINGVALE PHYSICAL THERAPY
Orthopedic Manual Physical Therapy, Sports, & Wellness
A Division of Massabesic Health Resources, P.A.

Disclaimer: Information collected about new clients is confidential and will be treated accordingly.

PATIENT INFORMATION

Full Name: _____ **Email:** _____

Address: _____

Home Phone: _____ **Cell Phone:** _____ **DOB:** _____

Age: _____ **Gender:** _____ **Social Security Number:** _____

Emergency Contact: _____ **Phone:** _____

Emergency Contact Relationship: _____

Employer: _____ **Occupation:** _____

Work Phone: _____

INSURANCE INFORMATION

Primary Insurance Company: _____

ID#: _____ Group#: _____

Policyholder Name: _____ DOB: _____

Relationship to Patient: _____

Secondary Insurance Company: _____

ID#: _____ Group#: _____

Policyholder Name: _____ DOB: _____

Relationship to Patient: _____

Is this an auto injury claim? YES NO **Is this a work injury claim?** YES NO

Date of injury: _____ Insurance name: _____

Address: _____

Claim #: _____ Adjustor Name: _____

Adjustor Phone number: _____ Adjustor fax: _____

REFERRING PHYSICIAN

Referring Physician: _____ **Phone:** _____

Primary Care Physician: _____ **Phone:** _____

I authorize my insurance benefits to be paid directly to Massabesic Health Resources, PA. I understand that I am financially responsible for any balance. I also authorize Massabesic Health Resources, PA. to release any information required to process my claims.

Patient/Guardian Signature: _____ **Date:** _____

CONSENT FOR CARE AND TREATMENT

As your sole provider of Physical/Occupational Therapy, it is our goal to develop a professional and personable relationship with you. With your permission, we will seek to contact members of your healthcare team to better understand your condition. We will explain to you all the treatment details during your therapy program before choosing a specific course of treatment. We invite you to be a part of the decision-making process along the way as we work in concert with you and your healthcare team. In the event that we need to contact you:

May we leave a message on your home or cell phone? Yes No
List names of any designated people we can leave a message with:

_____
_____
_____

I understand that, under the Health Insurance Portability & 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:

- furnish Physical/Occupational therapy services and treatment considered necessary and proper in evaluating or treating my physical condition
- furnish my physician, insurance company or attorney information concerning my injury and treatment
- Obtain payment for third party payers

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information and will be provided with that for review upon request. I understand this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact his organization at any time to obtain a current copy.

I understand that I agree to program participation including a home exercise program.

I, the undersigned, understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do, then you are bound to abide by such restrictions.

I understand that you may revoke this consent in writing at any time, except to the extent that you have acted relying on this consent.

PATIENT SIGNATURE

Signature: _____ Date: _____

Print Name: _____ Relationship to patient:_____

Office Copay, Cancellation, and No-Show Policy

We are dedicated to providing you with the best possible health care and are ready to help receive your maximum allowable benefits if you have medical insurance. To achieve these goals, you can assist us my reviewing our office and cancellation policies below.

Office Policy:

- Your copay is due at the same time of service. If you have a deductible that is greater than $500.00, we require a payment of $50.00 per visit to be applied toward that deductible until is has been met. We accept cash, checks, Visa, and Mastercard.
- There is a $25.00 service charge on all returned checks. Balances older than 30 days are subject to additional interest charges of 1.5% per month. You are also responsible for any collection fees for overdue accounts sent to a collection agency.

Cancellation/No-Show Policy:

Massabesic Health Resources, PA requires a 24-hour notice for the cancellation of any appointment. We understand that emergencies, poor road conditions, and other schedule conflicts may occur; please call us as soon as possible.

- After 2-consecutive cancellations of no shows without proper notice, you may be charged $40.00 per occurrence thereafter. This charge would not be covered by your insurance.
- Accident and Worker's Compensation claims adjusters expect regular attendance and adherence to your plan of care.
- Your pain may fluctuate as your course of treatment progresses. Having pain or not having pain are not reasons to cancel or fail to show for your scheduled treatment. If you are in pain, there are treatments available that can help lessen your pain. Likewise, if you are experiencing less pain, it is important to continue your treatments to correct the underlying cause of the pain. Missing appointments hinders that process and may end up prolonging recovery.
- If you are ever unsure about attending an appointment due to pain, please call to speak with your therapist directly.

Thank you for providing us with this courtesy.

Signing below indicates you understand and agree to the terms of this policy outlined above.

Patient signature:_____ **Date:**_____

PAYMENT AGREEMENT

Assignment of Insurance Benefits

I authorize that the payment of my insurance benefits be made directly to Massabesic Health Resources, PA for any services that are reimbursable by Medicare, Medicaid, or any third-party payors.

Guarantee or Payment

I understand that all payments designated as "the patients' responsibility" are due and payable at the time of service or billing. I guarantee that I will pay:

- My designated portion including co-pays/co-insurance, and my deductible
- All amounts due for services that my insurance company has stated are not covered benefits
- All amounts due for services billed by Massabesic Health Resources, PA but paid directly to me
- All amounts due for services billed by Massabesic Health Resources, PA to a Workers' Compensation payor which was subsequently declared by my employer to be a non-eligible claim
- All amounts due for claims submitted by Massabesic Health Resources, PA to my insurance company and not paid within 90 days. We will be in full communication with you and your insurance company in the event of this and will be happy to work with you.

Medicare and Workers' Compensation Information

I certify that the information I have provided to Massabesic Health Resources, PA for payment under the Social Security Act (Medicare) or under the Workers' Compensation Program is correct, including but not limited to any related accidents/illness or other insurers/payors available.

I,_____, understand the statements I have authorized above and declare their truthfulness.

Patient or Authorized Representative signature:_____

Date:_____

PATIENT INJURY OR CONDITION

Height: _____ **Weight:** _____ **Age:**_____

Type of Injury/Condition: _____
Date of Injury/Onset: _____

Type of Surgery/Procedure: _____
Date of Surgery: _____

Please describe your physical limitations as a result of this injury/surgery:

Please describe any activities or movements that aggravate your symptoms:

Please describe any treatments, movements, or self-care that decrease your symptoms:

Please list any previous injury, conditions, or surgeries:

Have you had any of the following diagnostic tests in relation to this injury?
☐ X-Ray ☐ MRI ☐ CT Scan ☐ Doppler ☐ Ultrasound ☐ Other: _____

Which of the following describes your pain? (check all that apply)
☐ Sharp ☐ Achy ☐ Burning ☐ Tingling ☐ Numbness ☐ Other: _____

Please rate your pain: *(0=None, 5=Moderate, 10=Severe)*

At present: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

At best: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

At worst: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Is your injury the result of a fall? ☐ Yes ☐ No

Have you fallen twice or more in the past year? ☐ Yes ☐ No

Dates of falls: _____

PATIENT MEDICAL HISTORY

Have you been diagnosed with any of the following conditions? (check all that apply)

- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder/Bowel problems
- ☐ Cancer
- ☐ Cardiac disease/conditions
- ☐ Pacemaker/defibrillator
- ☐ Circulation problems
- ☐ Currently pregnant
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness/vertigo
- ☐ Emphysema/Bronchitis
- ☐ Fibromyalgia/Chronic fatigue
- ☐ Fractures
- ☐ Gastrointestinal problems
- ☐ Gallbladder/Kidney problems
- ☐ Headache/Migraines
- ☐ Hepatitis
- ☐ Hernia
- ☐ High blood pressure
- ☐ Incontinence
- ☐ Metal implants
- ☐ Multiple sclerosis
- ☐ Neurological disorder
- ☐ Numbness/tingling
- ☐ Osteoporosis/Osteopenia
- ☐ Pain syndrome/CRPS
- ☐ Parkinson's
- ☐ Seizures
- ☐ Speech problems
- ☐ Strokes
- ☐ Thyroid problems
- ☐ Vision problems

Please describe in detail any diagnosis checked above:

Have you suffered from any illness not listed here? ☐ Yes ☐ No If yes, please explain:

TREATMENT HISTORY

Have you been treated for this condition before/have you had therapy services this year?
☐ Yes ☐ No
If yes, by whom? _____ Was it helpful? ☐ Yes ☐ No

What are your goals for Physical Therapy?

What do you hope to get out of your treatment?

What are your current physical or fitness goals?

Please list any important dates, such as return to sport/performance/games, coming up for which you want to be physically ready?_____

Are you currently taking any medications? ☐ Yes ☐ No Please list all medications and dosages:

_____

_____

_____

_____

_____

_____

_____

HEALTH HABITS & LIFESTYLE

Do you eat a well-balanced diet? ☐ Yes ☐ No

Do you drink water regularly? ☐ Yes ☐ No If yes, how many glasses per day? _____

Do you exercise regularly? ☐ Yes ☐ No If yes, how many times per week? _____
Exercise type/program: _____

Do you have any hobbies/leisure activities? ☐ Yes ☐ No Type: _____

Do you smoke? ☐ Yes ☐ No If yes, how many per day? _____
For how long? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how many per week? _____