PATIENT INFORMATION:

TODAY'S DATE: HOW DID YOU HEAR ABOUT US?:

LAST NAME: FIRST NAME:

STREET ADDRESS:

CITY: STATE: ZIP:

EMAIL ADDRESS:

MARTIAL STATUS: ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED ☐SEPARATED

BIRTHDATE: AGE: SEX: ☐MALE ☐FEMALE

EMPLOYER/SCHOOL:

EMPLOYER/SCHOOL ADDRESS:

PATIENT CONTACT PHONE NUMBERS:

HOME #: CELL #: WORK #:

SPOUSE/PARENT NAME: PHONE #:

EMERGENCY CONTACT: PHONE #:

BEST TIME AND NUMBER TO REACH YOU:

PHYSICIAN INFORMATION:

PRIMARY CARE PHYSICIAN NAME:

ADDRESS:

PHONE #: FAX #:

SPECIALTY PHYSICIAN NAME: SPECIALTY: ☐ORTHO ☐NEURO ☐OTHER_____

ADDRESS:

PHONE #: FAX#:

HEALTH INSURANCE INFORMATION:

PRIMARY INSURANCE COMPANY: SECONDARY INSURANCE COMPANY:

ID #: GROUP #: AUTH #:

INSURED'S NAME: INSURED'S SOCIAL SECURITY #:

DEDUCTIBLE: ☐YES ☐NO AMOUNT: PHYSICAL THERAPY CO-PAY: ☐YES ☐NO AMOUNT:

WORKER'S COMPENSATION/MOTOR VEHICLE ACCIDENT INFORMATION:

INSURANCE COMPANY: CLAIM #:

ADDRESS:

ADJUSTOR'S NAME: PHONE #:

INJURY DATE: OUT OF WORK: ☐YES ☐NO IF YES, SINCE:

ATTORNEY INFORMATION:

ATTORNEY NAME:

ADDRESS:

PHONE #: FAX #:

PATIENT MEDICAL HISTORY

PATIENT NAME (Please Print): _____

When did your symptoms begin? :_____
How did your symptoms begin? :_____
Have you had similar symptoms in the past? If yes, please describe : _____
_____
Have you been examined by a doctor for your symptoms? If yes, whom and when? :_____
_____
Have you had an MRI, X-Ray, Cat Scan or any other diagnostic procedure for your symptoms? If yes, please list :_____
Have you had any surgeries related to your symptoms? If yes, please list :_____
_____

How often do you experience your symptoms?

- ☐ Constantly (75-100% of the day)
- ☐ Frequently (50-75% of the day)
- ☐ Occasionally (25-50% of the day)
- ☐ Intermittently (0-25% of the day)

How much has your pain interfered with daily work and housework activities?

- ☐ Not at all
- ☐ A little bit
- ☐ Moderately
- ☐ Quite a bit
- ☐ Extremely

Which word describes the nature of your pain?

- ☐ Sharp
- ☐ Dull Ache
- ☐ Numb
- ☐ Shooting
- ☐ Burning
- ☐ Tingling

How much as your pain interfered with your social or recreational activities?

- ☐ Not at all
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time

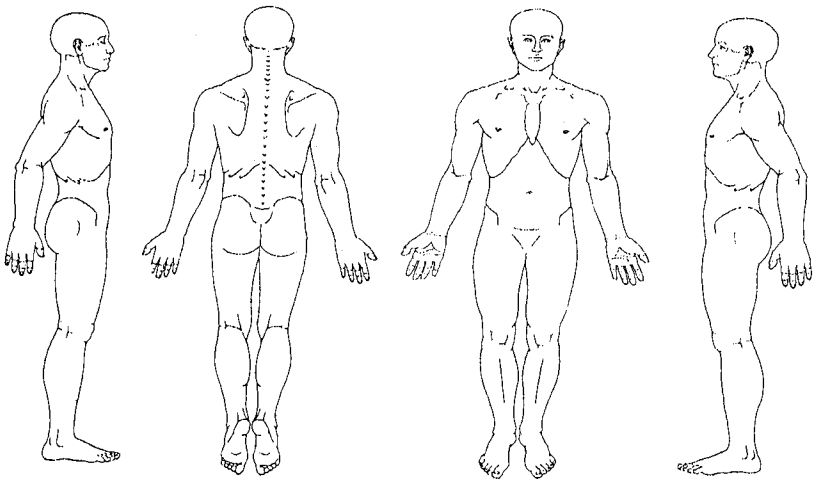
How are your symptoms changing?

- ☐ Getting better
- ☐ Getting worse
- ☐ Not Changing

In general, describe your overall health?

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor

On the diagram below, please circle the area of the body where you are having your symptoms:



On a scale of 0-10 (10 being the most severe), how would you rate your pain level:

With Activity: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
At Rest: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

I attest that the information listed above is accurate and current to the best of my knowledge:

PATIENT SIGNATURE: _____ **DATE:** _____

PATIENT MEDICAL HISTORY

PATIENT NAME (Please Print): _____

Please place an "X" in the appropriate boxes below to indicate **your personal** medical history:

ADD/ADHD	☐Yes	☐No	Gonorrhea	☐Yes	☐No	Polio	☐Yes	☐No
AIDS/HIV	☐Yes	☐No	Gout	☐Yes	☐No	Prostate Disease	☐Yes	☐No
Alcoholism	☐Yes	☐No	Heart Disease	☐Yes	☐No	Prosthesis	☐Yes	☐No
Anemia	☐Yes	☐No	Hepatitis	☐Yes	☐No	Psychiatric Care	☐Yes	☐No
Anorexia	☐Yes	☐No	Hernia	☐Yes	☐No	Rheumatoid Arthritis	☐Yes	☐No
Anxiety	☐Yes	☐No	Herniated Disk	☐Yes	☐No	Skin Conditions	☐Yes	☐No
Asthma	☐Yes	☐No	High Blood Pressure	☐Yes	☐No	Substance Abuse	☐Yes	☐No
Bleeding Disorders	☐Yes	☐No	High Cholesterol	☐Yes	☐No	Stroke	☐Yes	☐No
Bone Fractures	☐Yes	☐No	Liver Disease	☐Yes	☐No	Suicide Attempt	☐Yes	☐No
Bulimia	☐Yes	☐No	Measles	☐Yes	☐No	Thyroid Disease	☐Yes	☐No
Cancer	☐Yes	☐No	Mental Illness	☐Yes	☐No	Tuberculosis	☐Yes	☐No
Cataracts	☐Yes	☐No	Migraine Headache	☐Yes	☐No	Tumors or Growths	☐Yes	☐No
Chronic Bronchitis	☐Yes	☐No	Multiple Sclerosis	☐Yes	☐No	Ulcers	☐Yes	☐No
Chicken Pox	☐Yes	☐No	Osteoarthritis	☐Yes	☐No	Venereal Disease	☐Yes	☐No
Diabetes	☐Yes	☐No	Osteoporosis	☐Yes	☐No	Other_____		
Drug Addiction	☐Yes	☐No	Pacemaker	☐Yes	☐No	_____		
Emphysema	☐Yes	☐No	Parkinson's Disease	☐Yes	☐No	_____		
Epilepsy	☐Yes	☐No	Pinched Nerve	☐Yes	☐No	_____		
Glaucoma	☐Yes	☐No	Pneumonia	☐Yes	☐No			

Where do you work and what type of work do you do? : _____

_____

Is your work very physical or do you sit for most of your work day? :_____

_____

Are you currently taking any medications? If yes, please list : _____

_____

Do you use any vitamin, herb, or mineral supplements? If yes, please list : _____

_____

Do you have any allergies? If yes, please list : _____

Are you pregnant? If yes, what is your due date : _____

Do you live alone? If not, how many people do you live with? : _____

EXERCISE LEVEL:	WORK ACTIVITY:	HABITS:	
☐ None	☐ Sitting	☐ Smoke Tobacco	Packs/Day_____
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week_____
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine	Cups/Day_____
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	Reason_____

What type of exercise/sports do you enjoy? :_____

Do you practice yoga or stretch on a regular basis? If yes, how often? :_____

Do you belong to a gym or a fitness center? If yes, please list :_____

Have you had physical therapy in the past? If yes, when and why? :_____

_____

Have you had any surgeries in the past? If yes, please list date and type:_____

_____

I attest that the information listed above is accurate and current to the best of my knowledge:

PATIENT SIGNATURE: _____DATE:_____

PRECISION PHYSICAL THERAPY & SPORTS MEDICINE

5 High Street, Suite 203, Medford, MA 02155 • Tel: (781) 395-7333 Fax: (781) 395-7331

RESPONSIBILITY FOR PATIENT BENEFITS AND PAYMENT OF COPAYMENTS/DEDUCTIBLES/CO-INSURANCE

Please be advised that before you begin your physical therapy treatment at our facility, you need to contact your health insurance company to verify your physical therapy benefits. Your insurance plan may allow for only a specific amount of PT visits per calendar year (or fiscal period). Your insurance plan may also have a PT copay or a co-insurance or deductible or all the above. It is important that you know this information as you will be billed for any outstanding balances. As per your contract with your health insurance company, you are 100% responsible to have full knowledge your physical therapy insurance benefits. It is **NOT** the responsibility of Precision Physical Therapy to obtain this information, nor will your insurance company release this information to us because of HIPAA laws and regulations.

Also, it is possible that you may need an electronic authorization or a pre-certification from your primary care doctor before you begin treatment with us. Obtaining the electronic authorization or pre-certification from your PCP is **NOT** the responsibility of Precision Physical Therapy nor will your primary care doctor secure it for us because of HIPAA laws and regulations. If the authorization or pre-certification is not in place prior to starting PT this will cause denial of payment and you will be billed for any outstanding balances related to non-payment from your insurance company.

To obtain an authorization or pre-certification you will need our **NPI #** which is **1588678312** and our **fax #** which is **(781) 395-7331**. You will also need the start date of your physical therapy treatment which is the initial evaluation date (first visit).

If your insurance plan has a deductible or co-insurance or co-pay, we require that you keep a credit card, debit card or HSA (health savings account) card on file with our office. This account will be billed for any balances that will occur if your insurance plan does not pay in full for your PT visits. Your credit card number will be stored on our medical records system which is extremely secure, hack-proof and HIPAA compliant.

By signing this document, I am fully aware that I will be **100% responsible** for all unpaid balances that may incur if my health insurance does not pay for my visits.

Today's Date: _____/_____/_____

Patient Signature: _____

Printed Name: _____

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RELEASE OF MEDICAL RECORDS & AUTHORIZATION FOR TREATMENT

1. I hereby authorize Precision Physical Therapy & Sports Medicine to perform all necessary procedures and treatments as indicated for the delivery of outpatient physical therapy services.

2. I hereby authorize Precision Physical Therapy & Sports Medicine to release or receive from hospitals, physicians, and all other health professionals or facilities involved in my care, all medical records and information pertinent to my treatment or care.

3. I hereby authorize Precision Physical Therapy & Sports Medicine to utilize contracted personnel when necessary to enhance and make complete the plan of care.

4. I hereby authorize Precision Physical Therapy & Sports Medicine to furnish my insurance carrier all medical records that pertain to my current medical condition.

Today's Date: _____/_____/_____

Patient Signature: _____

Printed Name: _____

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CONSENT TO PHYSICAL THERAPY SERVICES

1. I authorize the performance upon myself of examinations and/or treatments performed by or under the direction of doctors, physical therapists, physical therapy assistance or physical therapy aides employed by Precision Physical Therapy and Sports Medicine.

2. I also consent to the performance of other diagnostic and therapeutic procedures in addition to, or from those stated above, whether or not arising from presently unforeseen conditions that the doctors, physical therapists, physical therapy assistants or physical therapy aides employed by Precision Physical Therapy & Sports Medicine may consider necessary or advisable in the course of my health care.

3. The nature and purpose or the procedures, the possible alternatives, the risks involved, the possible consequences, and the possibility of complication have been explained to me by the doctors, physical therapists, physical therapy assistants or physical therapy aides employed at Precision Physical Therapy & Sports Medicine.

4. I acknowledge that no guarantee or assurance as to the results that may be obtained from the procedure has been given by the doctors, physical therapists, physical therapy assistants or physical therapy assistants or physical therapy aides employed by Precision Physical Therapy & Sports Medicine.

Today's Date: _____/_____/_____

Patient Signature: _____

Printed Name: _____

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CANCELLATION AND TARDINESS POLICY

Dear Patient,

Welcome to our clinic!

We will strive to provide effective and efficient therapy services for you. We find it necessary to have some policies so we can provide the best care and make it available to as many people as possible.

1. We request a 24-hour notice for cancellations. We are very busy and another patient may benefit from having your scheduled time slot.

2. Please **do not** arrive early for your appointment. We treat patients on a very tight schedule and book on 15-minute intervals. There is no need to arrive too early as you may have to wait to be treated.

3. On that same token, we try our hardest to stay on schedule. If you are going to be late, please call the office to inform us. We may not be able to accommodate patients who are greater than 15 minutes late.

4. If you fail to show up for a scheduled appointment please call us within 24 hours to confirm your next appointment. If you do not contact us we will assume that you have decided to discontinue therapy and your future appointments may be removed from the schedule.

5. All patient scheduling is done at the front desk. Please be certain to confirm all changes or cancellations with the front desk, in addition to informing your therapist.

Thank you for your cooperation regarding our clinic policies. We attempt to give patients a schedule that is consistent. Please discuss your availability with your therapist to make the best arrangements.

Today's Date: _____/_____/_____

Patient Signature: _____

Printed Name: _____