Bay State Physical Therapy

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Name: _____

PCP: _____ Referring Physician (MD):_____

Please answer the following questions:

What injury or condition brings you here today? _____

When did you first notice your condition (date of onset)? _____

How did this injury occur? _____

Is your condition due to a motor vehicle accident? ☐ Yes ☐ No If yes, date of accident? _____

Have you had any falls in the past 12 months? ☐ Yes ☐ No If yes, how many times? _____

Did the fall(s) result in injury? ☐ Yes ☐ No If yes, please describe: _____

Please describe above: _____

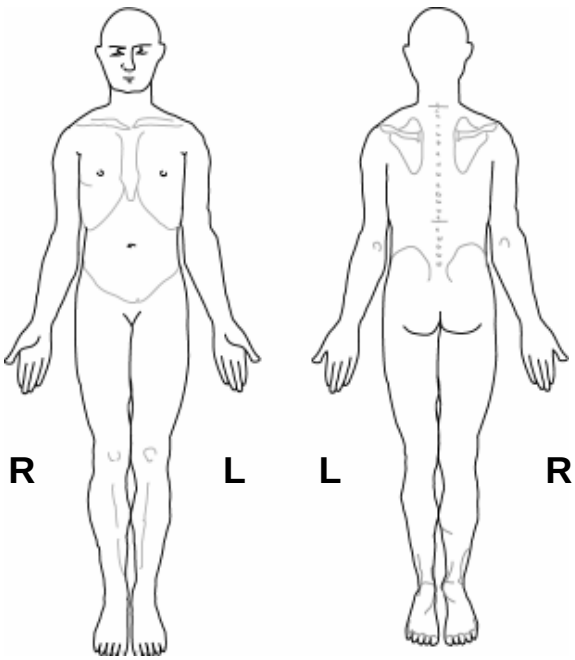
Are you seeing (or have you been seen by) any other specialists for your current condition (e.g.: doctor, psychologist, chiropractor, etc.)? Please list: _____

Have you been treated by another physical therapist in the past for this or any other condition? ☐ Yes ☐ No

If Yes, by whom/when? _____

What tests have you had for this condition? ☐ X-ray ☐ MRI ☐ CT scan ☐ Other: _____

Please mark where you have symptoms on the picture below. Also mark any areas of numbness/tingling or other unusual sensations:



Please circle/describe your symptoms:

Constant (24 hours/day)
Intermittent (comes and goes)
Knife-like/ Sharp
Burning
Pins and Needles
Dull
Numbness
Aching
Throbbing
Other: _____

Please circle the numbers that best correspond with your pain level at its BEST and its WORST (e.g. 3 and 8):

0	1	2	3	4	5	6	7	8	9	10
No pain		Mild pain, annoying		Nagging		Miserable, distressing		Intense, dreadful		Unimaginable

Since this condition began your symptoms have: ☐ decreased ☐ not changed ☐ increased

Bay State Physical Therapy

.

Your symptoms are worse in the: ☐morning ☐afternoon ☐night ☐same all day

What are your goals for physical therapy? _____

Please list past surgeries/conditions/hospitalizations:

_____ _____/_____/_____

_____ _____/_____/_____

_____ _____/_____/_____

_____ _____/_____/_____

Please list all medications, reason for taking and dosages (or you may attach a separate list):

_____ Dosage:_____

_____ Dosage:_____

_____ Dosage:_____

_____ Dosage:_____

Have you ever been diagnosed and/or treated for any of the following conditions (circle all that apply):

High Blood Pressure	Depression	Breathing Difficulties/ Asthma
Rheumatoid Arthritis	Cancer	Frequent Falls
Diabetes	Dizziness	Thyroid Problems
Osteoporosis	Bowel or Bladder Problems	Headaches
Heart Problems	Multiple Sclerosis	Stroke
Seizures	HIV/AIDS	Blood/clotting disorders
Kidney Problems	Hepatitis / Tuberculosis	Other: _____

Do you have a Pacemaker/Defibrillator? ☐ Yes ☐ No

For women: Are you pregnant? ☐ Yes ☐ No

Please list any allergies that you have (For example: medications, latex, food, bee stings): _____

Is there any additional information? _____

_____

The above information is true to the best of my knowledge.

Signature: _____ Date: ___/___/_____

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Personal Insurance Intake Form

Patient Information

Name: _____ Date of Birth: _____/____/____
Sex: M or F Social Security: _____-___-____

Address: _____
Street City State Zip

Email Address:_____

Home Phone: _____Work Phone: _____Cell Phone: _____

Best Way to contact you: Email Cell (Text Message) None (circle)

Occupation: _____
Employer: _____

If under 18 years, name of Parent or Guardian: _____

Emergency Contact: _____ Relation: _____
Emergency Contact Phone Number: _____

PCP Name: _____ Phone: _____

Insurance Information:
Primary Insurance Company: _____ Policy Holder Name: _____

Insurance ID #: _____ Policy Holder Date of Birth: _____.

Secondary Insurance Company: _____ Policy Holder Name: _____

Insurance ID #: _____ Policy Holder Date of Birth: _____.

Patient Signature:_____ Date:_____

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Acknowledgement of Office Policies

The following are Bay State Physical Therapy's policies governing appointment scheduling, payment terms, and information releases. ***Please read carefully*** *before signing, and be sure to ask questions you might have before signing the document.*

Appointment Scheduling. We at Bay State Physical Therapy are glad to accept insurance assignment on your behalf in handling your personal injury or worker's compensation claim. However, in order to help ensure that your insurance company pays for the care you receive here, it is important that you adhere to the recommended care program. We require a 24 hour cancellation notice for all appointments. If you miss three (3) appointments in a three (3) week period without notifying Bay State (emergencies considered), you may be dismissed from care and your file may be closed. *We only treat those patients who want to get well.*

Consent for Treatment. I, the undersigned, give Bay State Physical Therapy my permission to evaluate and treat my injury. I further understand that in the course of recommended treatment, condition may worsen on rare occasions. I further understand that no guarantee or promise has been made to me concerning the results of treatment.

Assignment of Payment. I hereby authorize my insurance company and/or my attorney to pay direct to Bay State Physical Therapy, PC any monies due on my account for professional services rendered.

Acknowledgment and Understanding. It is further understood that I, the undersigned, agree to pay the full amount of the charges should my condition be such that it is not covered by my policy, or if, for any reason, the insurance company and/or my attorney refused to pay my balance at this office.

Private Health Insurance. I understand that I am responsible for whatever fees my insurance company does not pay on my claim. (Typically, this includes deductibles and/or co-payments).

Authorization to Release Information. I authorize this office to release any information pertinent to my case to any insurance company or attorney to facilitate collections on my balance at this office.

Patient Requests for Records: I instruct the release of all medical, hospital, or surgical records pertinent to my case, including but not limited to exams, special test, x-rays, or lab results to this office.

I certify that I have read and understand all appointment and office policies listed above.

Patient Signature: _____ **Date:** _____

Name (Please Print): _____

Witness Signature: _____ **Date:** _____

Name (Please Print): _____

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BAY STATE PHYSICAL THERAPY
Physical Therapy at its Best!

Patient Information Consent Form

I have read and fully understand Bay State Physical Therapy's Notice of Information Practices. I understand that Bay State Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payments, understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operation if I notify the practice. I also understand that Bay State Physical Therapy will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Bay State Physical Therapy's Notice of information practices. I understand that I retain the right to revoke this consent by not signing the practice at any time.

_____
Patient Name

_____
Signature

_____
Date

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Designate Individuals Authorization Form

I hereby authorize one or all of the designated parties listed below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Please give the name(s) of the individual(s) who you will allow to receive any part(s) of your health record.

Authorized Designees:

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

_____
Patient Name

_____
Patient Signature

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PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of Bay State Physical Therapy's *Notice of Privacy Practices for Protected Health Information.*

_____	_____
Patient Name Printed	Date
_____	_____
Patient Signature	Authorized Provider Rep.
_____	_____
Personal Representative Printed	Personal Rep. Signature

Description of personal representative's authority to act for the patient