

# MASS SPORT & SPINE

## Physical Therapy



Referring Doctor's First and Last Name & Phone Number

\_\_\_\_\_

Primary Care Physician's First and Last Name & Phone Number

\_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Ph#: \_\_\_\_\_ Cell Ph#: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_ Parents Name (under 18) \_\_\_\_\_

Email \_\_\_\_\_

How did you hear about Mass Sport & Spine? \_\_\_\_\_

### PATIENT WORK INFORMATION

Employer's Name \_\_\_\_\_

Employer's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_ Work Phone No. \_\_\_\_\_

Occupation \_\_\_\_\_

●●●**I AM RESPONSIBLE TO KNOW MY INSURANCE BENEFIT**●●●

*Please Initial Here:* \_\_\_\_\_

### AUTHORIZATION TO PAY MASS SPORT & SPINE

#### Assignment of Benefits

I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO MASS SPORT & SPINE AND I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES. I ALSO AUTHORIZE MASS SPORT & SPINE TO RELEASE ANY INFORMATION TO PROCESS THIS CLAIM.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

#### Consent:

I, the undersigned, voluntarily authorize Mass Sport & Spine to administer physical therapy that is necessary as appropriate in the opinion of the referring physician and/or the allied health personal. Physical therapy is not an exact science and no guarantee has been made to the result of any treatment administered. By signing this, I acknowledge receipt of the Notice of information practices of Mass Sport & Spine. I Also acknowledge I have read the clinic polices posted at the front desk.

→Signature \_\_\_\_\_ Date \_\_\_\_\_

# MASS SPORT & SPINE Physical Therapy



## Private Insurance Information

*Without this information we can not bill your insurance correctly.*

*\*Insurance Subscriber and Date of Birth* \_\_\_\_\_

Relationship to the insured \_\_\_\_\_ Policy \_\_\_\_\_

Group Number \_\_\_\_\_ Insurance Company Name \_\_\_\_\_

Copay Amount \_\_\_\_\_ Deductible or Coinsurance amount \_\_\_\_\_

## Secondary Insurance Information

Name of insured \_\_\_\_\_ Relationship \_\_\_\_\_

Insurance Policy No. \_\_\_\_\_ Group No. \_\_\_\_\_

Insurance Company Name \_\_\_\_\_

Copay amount \_\_\_\_\_ Deductible or Coinsurance amount \_\_\_\_\_



**\*ONLY -If you're here because of an auto accident or workers comp incident\*\*\*\***

## Auto Insurance Information

Name of insured \_\_\_\_\_

Auto Insurance Company Number \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Claim Number \_\_\_\_\_

Adjustor's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

## Worker's Compensation Information

Employer's Name (at time of injury) \_\_\_\_\_

W/C Insurance Company Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Claim Number \_\_\_\_\_

Adjustor's Name \_\_\_\_\_ Ph# \_\_\_\_\_

## Attorney Information

Name \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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### IMPORTANT COMPANY POLICIES:

We strive to provide you with the best personalized care available. To make this possible we adhere to a set of very important policies. Please read them carefully and indicate your agreement by signing at the bottom.

#### **Please give 24 hour advance notice:**

If you wish to change or cancel an appointment we require a minimum of 24-hour advance notice. Anything less than that will result in a \$25.00 fee applied to your account. It costs us approximately \$57.00 to offer you a single appointment. But we don't charge you that. We merely charge \$25.00 not to make money, but to act as a deterrent from making last minute changes.

Advance notices allows someone else (who needs it) time to reserve it in place of you. Please be courteous and responsible. Thank you.

#### **No Shows:**

We understand things happen. If you are unable to keep your appointment please call and let us know. Simply not showing up will result in the loss of all scheduled future appointments. New appointments will be allowed on a "first-come, first-serve basis".  
**ALL NO SHOWS WILL BE CHARGED A FEE OF \$25.00.**

#### **Late Policy: 10 minutes**

Being late by more than 10 minutes will require you to reschedule. If we allow a patient in for treatment later than 10 minutes from their appointed time, it will overlap and compromise the care of another patient. We do not allow this. Please call and reschedule for another day.

I have carefully read and agree to all of the above policies. In the event such policies are broken, I agree to the consequences set forth.

Please sign that you have read these policies:

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

# MASS SPORT & SPINE Physical Therapy



## History of Present Illness:

For what condition or symptoms are you being seen for at this time?

(Right or Left) \_\_\_\_\_

\_\_\_\_\_

When did this condition begin? \_\_\_\_\_

What treatment have you already received \_\_\_\_\_

\_\_\_\_\_

Have you had PT in THIS Calendar year?? Y or N

Has this problem occurred in the past? \_\_\_\_\_

Please list or supply us with a list of all medications that you are currently taking: \_\_\_\_\_

\_\_\_\_\_

## **Past Medical History:**

Please indicate all past surgeries: \_\_\_\_\_

Do you have a history of Falls? \_\_\_\_\_

If Yes, when was your last fall? \_\_\_\_\_

*Please indicate whether you have had the following conditions:*

Cancer \_\_\_\_\_

Heart Disease \_\_\_\_\_

Arthritis/Gout \_\_\_\_\_

High Blood Pressure \_\_\_\_\_

Bleeding Tendency \_\_\_\_\_

Diabetes \_\_\_\_\_

Stroke \_\_\_\_\_

Kidney or Bladder Problem \_\_\_\_\_

Respiratory Disease \_\_\_\_\_

Pneumonia/emphysema \_\_\_\_\_

Asthma \_\_\_\_\_

Hernia \_\_\_\_\_

Thyroid Disorder \_\_\_\_\_

Other: \_\_\_\_\_ Are you pregnant?: \_\_\_\_\_

Do you have any surgical implant/Pacemaker? \_\_\_\_\_

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### MASS SPORT & SPINE NOTICE OF INFORMATION PRACTICES

#### UNDERSTANDING YOUR HEALTH INFORMATION RIGHTS:

Although your health record is the physical property of the healthcare provider, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information (45CFR164,522)
- Obtain a paper copy of the notice of information upon request
- Inspect and obtain a copy of your health record (45 CFR164,524)
- Request and amend your health record (45 CFR 164,528)
- Obtain an accounting of disclosures of your health information (45 CFR 164,528)
- Request communications of your health information by alternative means or alternative locations
- Revoke your authorization to use or disclose health information except to the extent that actions has already been taken

#### OUR RESPONSIBILITY:

We are required to:

- Maintain privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to your information
- Abide by the terms of this notice
- Accommodate reasonable requests you may have to communicate health information by alternative means or locations. We reserve the right to change our practices and to make the changes effective for all protected health care information we maintain. If our information practices change we will notify you the next time you come in to our office for treatment.

If you have any questions and would like additional information, you may contact Health and Human Services. If you believe your privacy rights have been violated you can file a complaint with the secretary of Health and Human Services. We will not retaliate if you file a complaint.

Examples of Disclosures for treatment, Payment and Health Operations

*We will use and disclose your health information for treatment for example:* information obtained by us will be recorded in your record and used to determine the course of treatment that should work best for you. Members of your healthcare team will then record the actions they took and their observations. In that way your physicians and other providers will know how you are responding to treatment. Copies of these records as well as other reports will be provided to others providers participating in your care to assist them in treating you if you are referred to them for consultation.

*We will use and disclose your health information for payment.* For ex., a bill may be sent to you or a third-party payer. The information on or accompanying the bill may

EFFECTIVE DATE APRIL 14, 2003

include information that identifies you, as well as your diagnosis, procedure and supplies used. Additionally, we may be required to forward additional information to substantiate the medical necessity of the care delivered and that the care for which the claim was submitted was actually delivered. Further, we may disclose health information to the extent authorized and to the extent necessary to comply with worker's compensation or other similar programs established by law.

*We will use and disclose your health information for regular health operations.* For example, members of our staff may use the information in your health record to phone you regarding confirmation of appointments or to notify patient of missed appointments. Logistics may dictate the portions of treatments are conducted in an open gym atmosphere where disclosures may be overheard. Every reasonable precaution is taken to limit these events.

*Business Associates:* There are some services provided in our organization through contracts with business associates. Examples include services by laboratories, copy services, and transcription services. When these services are contracted, we may disclose your health information to our business associate so that they can perform their job we've asked them to do. However, to protect your health information we require the business associate to appropriately safeguard your information.

*Notification:* We may use or disclose information or assist in the notifying a family member, personal representative or another person responsible for your care, of your location, and general condition.

*Family Communication:* After careful judgment, we may disclose to a family member or other person you designate health information relevant in that person's involvement in your care or payment related to your care, of your location and general condition.

Funeral Directors & Organ Procurement Organizations We may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

*Public Health* As required by law, we may disclose health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

*Law Enforcement and Correctional Institution* We may disclose health information for law enforcement purposes required by law should you be an inmate of a correctional institution; we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

*Federal Law* makes provision for your health information to be released to an appropriate health oversight agency, public health authority, provided that we or our business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.