

PRO SPORTS THERAPY, INC. (P.S.T.)

PATIENT INFORMATION SHEET

Account Number: _____

Date: _____

Patient Name:		Date of Birth:	Marital Status:
Mailing/Local Address:		Telephone: Home: _____ Work: _____ Mobile: _____ Other: _____	
Permanent Address:		Email address:	
Name of legal guardian, if under age:		Emergency contact name:	
Contact phone number of legal guardian:		Emergency contact phone number:	
Your relation with the legal guardian:		Your relation with the emergency contact:	
Employer Name:		Work Address:	
Primary Care Physician:		Telephone:	
Referring Specialist:	Specialty:	Telephone:	

PRIMARY MEDICAL INSURANCE INFORMATION

Please Check One below: The primary payor for my claims is

Workers' Compensation **Motor Vehicle Accident** **Health Insurance** **Self**

(If this is a Workers' Compensation claim, please provide the proper insurance carrier information below, otherwise please provide your primary health insurance information)

Insurance Company:		Telephone:	
Street Address:	City:	State:	Zip:
**Subscriber's Name:		Subscriber's Date of Birth:	
Insurance Group Number:	Insurance I.D. Number:	Subscriber's Social Security Number:	
Subscriber's Employer:		Your relation with the subscriber:	

For Workers' Compensation claims only: Claim or Case number: _____

Claim Adjuster's Name: _____ Telephone: _____

** If you have this policy through your spouse, parents or other sources, he or she will be the subscriber of your insurance policy.

840 Winter Street, Waltham, MA 02451
 334 Littleton Road, Westford, MA 01886

Tel: (781) 487-9944 Fax: (781) 487-9966
 Tel: (978) 392-0483 Fax: (978) 392-0947

PRO SPORTS THERAPY, INC. (P.S.T.)

BILLING POLICY

Name: _____

Account #: _____

HEALTH INSURANCE CARD: Please have this with you when you register with our staff. If your insurance policy should change, please notify our office immediately. If your claims are denied by your insurance company because we do not have the correct insurance info from you, you will be held financially responsible for the claim(s) denied.

INSURANCE BENEFIT: It is your responsibility to verify physical therapy benefit with your insurance company. P.S.T. will also verify it only as a courtesy. Any information provided to us by the insurance company at the time of verification does not guarantee accuracy and payment, and the benefit is subject to the provision of your policy at the time when insurance company processes your claims.

AUTHORIZATION/REFERRAL: If your insurance policy requires one, you are responsible to provide it at the time of your initial visit, and to provide more as needed to continue your treatment. You will keep track of your visits not to exceed the number of visits authorized on the referral and not to go beyond the expiration date. You will be responsible for any visits that are not covered by authorization/referral at the time of the visits.

MEDICAL NECESSITY: Your insurance will only pay for the PT services that are medically necessary. Medical necessity is to be established by the referring physician(s) and the treating therapist(s). If your insurance determines that the PT services you receive are not medically necessary and therefore denies the claims, you will be held responsible for the denied claim. You can appeal the denial with your insurance and we will provide all the medical documents we have to assist you with the appeal process.

MOTOR VEHICLE ACCIDENT AND OTHER THIRD PARTY LIABILITY CLAIMS: P.S.T. will not bill MVA insurance carriers or attorneys for services rendered. All visits are to be paid in full at the time of the visits. P.S.T. will assist you in obtaining payment from the insurance company by providing any necessary documentation at your request.

WORKER'S COMPENSATION CLAIMS: You need to provide us with your date of injury, claim number, case adjustor's name and telephone number prior to your first visit. We reserve the right to cancel your appointment until the worker's comp claim is verified and approved.

CONSENT TO RENDER PAYMENT: You hereby authorize the payment of medical benefits to P.S.T. for services rendered. P.S.T. agrees to bill your insurance company as a courtesy, however, should the insurance company delay payment, pend or deny claims beyond 60 days of submission, You will be responsible for payment in full to P.S.T. within 10 days of notification from insurance company or P.S.T. billing department.

DEDUCTIBLE, CO-INSURANCE & CO-PAYMENT: You hereby agree to pay all the deductible, co-insurance & co-payments if required by your insurance policy at the time of your visits. This is your contractual obligation with your insurance company and we are mandated to collect it from you. Please be aware that the exact amount of your out of pocket payments will be determined at the time your claims are processed, therefore they might be different from what P.S.T. verifies with your insurance company at the beginning of your treatment course should your benefit changes. Please retain all your receipts as we will not be able to reconcile any balance discrepancy without proof of payment.

NOTICE OF CANCELLATION OF APPOINTMENTS: A twenty-four (24) hour notice must be given to P.S.T. to cancel an appointment. Should you cancel an appointment within 24 hours or fail to appear for a scheduled appointment without notice, a \$25.00 late cancellation/no show fee will be assessed.

PREVIOUS TREATMENT: It is your responsibility to inform the staff at P.S.T. if you have received medical treatment elsewhere for the same or other injuries because you might have used part of, if not all, your insurance benefit. It is also your responsibility to find out the availability of your Physical Therapy benefit from insurance company, if you have been treated for the same or other injuries before. By not providing this important information, your will be held responsible for any charges that are rejected by insurance company due to benefit exhaustion. Please check one and initial below:

NO, I have not received any PT/OT/Chiro treatment this year. Initial _____

YES, I have received PT/OT/Chiro treatment this year. How many visits? _____ Initial _____

*** If you checked off yes, please provide detailed information regarding previous treatment, if any, in the patient history questionnaire.

PATIENT STATEMENTS: All bills are payable within 30 days of receipt. Failure to response to our patient statements after 60 days will result in your account being turned over to a collection agency and a \$25.00 collection fee will be assessed. Your credit rating will be affected.

I have read the insurance policy and I fully understand my responsibilities as a patient.

Signature _____

Date _____

840 Winter Street, Waltham, MA 02451
 334 Littleton Road, Westford, MA 01886

Tel: (781) 487-9944 Fax: (781) 487-9966
Tel: (978) 392-0483 Fax: (978) 392-0947

PRO SPORTS THERAPY, INC. (P.S.T.)

NOTICE OF HEALTH INFORMATION/PATIENT PRIVACY PRACTICES

Name: _____

Account #: _____

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

INTRODUCTION

At Pro Sports Therapy, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 15, 2003, and applies to all protected health information as defined by federal regulations.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit Pro Sports Therapy; a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of Pro Sports Therapy, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

OUR RESPONSIBILITIES

Pro Sports Therapy is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of this provider's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning my personal medical information:

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed: _____

Date: _____

840 Winter Street, Waltham, MA 02451
 334 Littleton Road, Westford, MA 01886

Tel: (781) 487-9944 Fax: (781) 487-9966
Tel: (978) 392-0483 Fax: (978) 392-0947

PRO SPORTS THERAPY, INC. (P.S.T.)

AUTHORIZATION TO USE AND DISCLOSE PATIENT INFORMATION

Name: _____

Account #: _____

As a patient of Pro Sports Therapy, you have the right to know how we may use and disclose information about you. Information about our disclosures is provided in our Notice of Patient Privacy Practices, and a copy of this notice has been provided to you. You have the right to review our notice before signing this form. You should read our Notice carefully before signing this form. As our Notice of Privacy Practices explains, we need your authorization to use or disclose information about you for any purpose other than treatment, payment or normal healthcare operations.

1. I authorize the use and disclosure of my protected health information for the following purpose(s)

2. By initialing and signing below, I authorize the use and disclosure of the following types of Protected Health Information that may pertain to any health care I have received to date: (please initial the category of information you wish to authorize use and disclosure)

_____ My entire medical record
_____ Information related to _____ only.

3. I authorize my Protected Health Information to be disclosed to:

Name _____ Relationship: _____
Name _____ Relationship: _____
Name _____ Relationship: _____
Name _____ Relationship: _____

4. I HAVE BEEN TOLD THAT INFORMATION OTHERWISE PROTECTED BY LAW AND DISCLOSED UNDER THIS AUTHORIZATION MAY BE SUBJECT TO RE-DISCLOSURE, AND MAY NO LONGER BE PROTECTED BY LAW, INCLUDING BUT NOT LIMITED TO PRIVACY REGULATIONS ISSUED BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

5. I agree that this authorization for use and disclosure of my identifiable health information will be effective from the date I sign this document until this authorization expires or until I revoke this authorization. I understand that I may revoke this authorization at any time by giving Pro Sports Therapy notice in writing at 840 Winter Street, Waltham, MA 02451. I also understand that treatment, payment, enrollment in a health plan, or eligibility for certain health benefits cannot be conditioned on my providing this authorization. **This authorization will expire upon my discharge from Pro Sports Therapy**

By signing below I agree that my Protected Health Information may be used or disclosed as described above.

Printed Name of Patient: _____

Printed Name of Legally Authorized Representative _____

Signature of Patient or Legally Authorized Representative

Date

840 Winter Street, Waltham, MA 02451
 334 Littleton Road, Westford, MA 01886

Tel: (781) 487-9944 Fax: (781) 487-9966
Tel: (978) 392-0483 Fax: (978) 392-0947

PRO SPORTS THERAPY, INC. (P.S.T.)

PATIENT HISTORY OF PRESENT INJURY/CONDITION

Account #:

Date:

Patient Name:

Age:

Sex:

What is your injury/reason for coming for physical therapy?

Current problem is the result of a(n): work accident motor vehicle accident sports injury
 chronic condition other, please describe

Where did the injury happen: work place home school commercial property
 other, please describe

How long have you had your present injury/problem?

Have you had any of the following medical tests done? MRI X-Ray CT Scan
 other, please describe _____

Where can we obtain a copy of the test results?

Previous treatment on this and any other injuries/conditions within one year:

PT OT Chiro for: _____ From: _____ To: _____

At: Home Nursing Home Hospital Here Other: _____

PT OT Chiro for: _____ From: _____ To: _____

At: Home Nursing Home Hospital Here Other: _____

PT OT Chiro for: _____ From: _____ To: _____

At: Home Nursing Home Hospital Here Other: _____

What activities/positions help your present injury?

What activities/positions aggravate your present injury?

On a scale of 0 – 10, (10 being most painful) how severe is your pain?

On a scale of 0 – 10, (10 being most normal) how much function do you have?

Have you had other injuries/conditions that you believe contribute to your present injury/problem?

Please state your goals in physical therapy:

Are you taking any medication specifically for your present injury? If yes, please list the medications below.

How did you hear about P.S.T.? Doctor's referral Yellow page Family/Friend NEPTN Insurance company
reference Other (please describe) _____

PRO SPORTS THERAPY, INC. (P.S.T.)

PATIENT MEDICAL HISTORY QUESTIONNAIRE

Account #:

Date:

Patient Name:

Age:

Sex:

Are you currently working? NO YES If yes, occupation:		
Are you currently having or have you had the following condition: (if yes, please describe)		
Heart condition	NO YES	
High Blood Pressure	NO YES	
Lung/Breathing	NO YES	
Allergies	NO YES	
Asthma	NO YES	
Cancer	NO YES	Location: Any treatment?
Diabetes	NO YES	Type: Insulin dependent: NO YES
Epilepsy/Seizure	NO YES	Type of seizure:
Pregnancy	NO YES	Due date:
Osteoporosis	NO YES	Location: Bone density testing: NO YES
Arthritis	NO YES	Location:
Musculoskeletal problems:	NO YES	Location:
Have you fallen in the past 12 months? NO YES If yes, how many times did you fall?		
What was the injury, if any?		
Previous Surgeries: Please list types of surgeries and approximate dates:		
Type: _____	Date: _____	
Type: _____	Date: _____	
Type: _____	Date: _____	
Previous Fractures:		
Location: _____	Date: _____	<input type="checkbox"/> Casted <input type="checkbox"/> Surgical fixation
Location: _____	Date: _____	<input type="checkbox"/> Casted <input type="checkbox"/> Surgical fixation
Location: _____	Date: _____	<input type="checkbox"/> Casted <input type="checkbox"/> Surgical fixation
Other:		
Please list all current medications, including prescription, over-the-counter, herbals, vitamin/mineral/dietary supplements.		
<input type="checkbox"/> Check this box if attaching a separate sheet for medications		
Name of medications:	Dosage:	Frequency and how you take it:

