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

PATIENT INFORMATION SHEET

Account Number: Date:

Patient Name:			Date of Birth:
Mailing/Local Address			Telephone: Home: Work: Mobile:
Marital Status:	Social Security Number:		
Name of legal guardian, if under age:			Contact phone number of legal guardian:
Address of legal guardian:			
Emergency contact name:			Emergency contact phone number
Employer:			Telephone:
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 Tel: (781) 487-9944 Fax: (781) 487-9966

☐ 235 Littleton Road, Suite #2, Westford, MA 01886 Tel: (978) 392-0483 Fax: (978) 392-0947

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

BILLING POLICY

Account #: Date:

Name: ____

HEALTH INSURANCE CARD: Please have this with you when you register with our staff. If your insurance should change, please notify the office as soon as possible.

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 payment and the benefit is subject to the provision of your policy at the time when insurance company processes your claims.

REFERRALS: If your insurance policy requires referrals, you are responsible to provide one 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 referrals at the time of the visits.

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: You need to provide us with your date of injury, claim number, case adjustor's name and telephone number at 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 AND CO-INSURANCE: You hereby agree to pay all the deductible and co-insurance payments if required by your insurance policy at the time of your visits. This is a contractual obligation with your insurance company and we are mandated to collect it from you. Please be aware that the exact amount of your deductible and co-insurance payments will be determined at the time your claims are processed, therefore they might be different from what P.S.T. verify with your insurance company at the beginning of your treatment course should your benefit level change.

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, a $25.00 cancellation fee may 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 any 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 no received any PT/OT/Chiro treatment this year. Initial __________

☐ **YES,** I have received PT/OT/Chiro treatment this year. How many visits? ___________ Initial __________

*** 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** ____________________

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

NOTICE OF HEALTH INFORMATION/PATIENT PRIVACY PRACTICES

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 heath 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:**______________________

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

AUTHORIZATION TO USE AND DISCLOSE PATIENT INFORMATION

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 your 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

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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 medicine for your present injury? If yes, list all medications.

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 your currently having or have you had the following condition: (if yes, please describe)

Condition						
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: ☐ Casted ☐ Surgical fixation

Location: Date: ☐ Casted ☐ Surgical fixation

Location: Date: ☐ Casted ☐ Surgical fixation

Other:

Medications: Please list