Account #: ____________

PRO SPORTS THERAPY, INC.
PATIENT INFORMATION

Patient Name:	Date of Birth:
Occupation:	Marital Status:
Mailing/ Local Address:	Primary Telephone Number: Email Address:
Emergency Contact Name: Telephone Number: Relationship:	Legal Guardian Name: Telephone Number: Relationship:
Referring Specialist: Telephone:	Primary Care Physician: Telephone:

INSURANCE INFORMATION, PLEASE CHECK ONE:

The primary payer for this injury is: ☐Health Insurance ☐Workers' Compensation ☐Motor Vehicle Insurance
(If this is a workers' compensation claim, please provide the workers' compensation carrier information below).

Insurance Company:		Telephone:	
Street Address:	City:	State:	Zip:
Subscriber's Name:	Subscriber's Date of Birth:	Relationship to Subscriber:	
Insurance Group Number:	Insurance I.D. Number:		
Workers' Compensation Claim or Case number: Claim Adjuster's Name and Telephone:			

BILLING POLICY: _________ By initialing here, I acknowledge Pro Sports Therapy, Inc. may charge $50.00 for each appointment canceled less than 24 hours from the time of the appointment and for failing to show for an appointment. I agree to provide Pro Sports Therapy, Inc. with accurate health insurance information and I hereby authorize Pro Sports Therapy, Inc. to bill my insurer. I acknowledge I may have a deductible, co-insurance, and/ or co-payment per the terms of my insurance policy and I agree to pay such obligation at the time of each visit. I understand my insurance may require a referral, which I must obtain prior to treatment. I agree to inform Pro Sports Therapy, Inc. of prior physical therapy (PT), occupational therapy (OT), and chiropractic treatment I received within twelve (12) months of my treatment at Pro Sports Therapy, Inc. I understand prior treatment may affect my insurance coverage. I have the right to receive a copy of Pro Sports Therapy, Inc.'s complete Billing Policy.

☐ **NO**, I have not received PT/OT/Chiro treatment in the last twelve (12) months.

☐ **YES**, I have received PT/OT/Chiro treatment in the last twelve (12) months. How many visits? ___________

CONSENT: _________ By initialing here, I consent to the use or disclosure of my protected health information (PHI), which includes my demographic information and health information, and is further defined in the Health Insurance Portability and Accountability Act of 1996. I hereby authorize Pro Sports Therapy, Inc. to use my PHI for the purposes of providing treatment to me, for obtaining payment for said treatment, and for conducting healthcare operations. I understand I have the right to request a restriction on how Pro Sports Therapy, Inc. uses or discloses my PHI. I hereby acknowledge I have received Pro Sports Therapy, Inc.'s Notice of Privacy Practices and Authorization to Use and Disclose Protected Health Information.

Account #: ____________

PRO SPORTS THERAPY, INC.

PATIENT MEDICAL QUESTIONNAIRE

Patient Name:	Date of Birth:
What is your reason for coming for physical therapy?	
Injury is the result of: ☐work accident ☐motor vehicle accident ☐sports injury ☐chronic condition ☐other:	
Where did the injury happen: ☐work ☐ home ☐school ☐other:	
How long have you had your present injury?	
Have you had any of the following for this injury? ☐MRI ☐X-Ray ☐CT Scan ☐other: Where may we obtain a copy of the results?	
Previous treatment on this and any other injuries/ conditions in past 12 months: ☐PT ☐OT ☐Chiro for: ____________________ At: ☐Home ☐Hospital ☐PST ☐Rehabilitation Center ☐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?	
Please state your goals in physical therapy:	
Have you fallen in the past 12 months? ☐ YES ☐ NO If yes, how many times? Were you injured?	
Previous Surgeries and Fractures: Type/ Location: Date:	
Type/ Location: Date:	
Type/ Location: Date:	
Have you been diagnosed with the following: Asthma ☐YES ☐NO High Blood Pressure ☐ YES ☐ NO Epilepsy/ Seizure ☐ YES ☐ NO Allergies ☐YES ☐NO ____________ Arthritis ☐YES ☐NO ____________ Cancer ☐YES ☐NO ____________ Diabetes ☐YES ☐NO ____________ Heart Condition ☐ YES ☐ NO ____________ Musculoskeletal ☐ YES ☐ NO ____________ Osteoporosis ☐ YES ☐ NO ____________Respiratory ☐ YES ☐ NO ____________	
Please list all current prescription and over-the-counter medications, herbals, and supplements.	

Account #: ____________

PRO SPORTS THERAPY, INC. NOTICE OF PRIVACY PRACTICES

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

INTRODUCTION: At Pro Sports Therapy, Inc., (PST) we are committed to using your protected health information responsibly. This Notice describes the protected health 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, is protected health information and serves as a:

- Basis for planning your care and treatment
- Means of communication among health professionals who contribute to your care
- A tool with to assess and with intent to improve the care we render and outcomes
- Information for PH officials charged with improving the health of this state and the nation
- Legal document describing the care you received
- A source of data for our planning and marketing
- A source of data for medical research
- A tool in educating health professionals

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

YOUR HEALTH INFORMATION RIGHTS: Although your health record is the physical property of PST, the information belongs to you. You have the right to:

- Obtain: a paper copy of this Notice upon request and an accounting of disclosures of your health information as provided in 45 CFR 164.528
- Amend your health record as provided in 45 CFR 164.528
- Inspect and copy your health record as provided for in 45 CFR 164.
- 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
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

OUR RESPONSIBILITIES: PST is required to:

- Maintain the privacy and confidentiality of your individually identifiable and protected health information
- Provide you with this Notice and abide by the terms of this Notice;
- Notify you if we are unable to agree to a requested restriction
- 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. In the event you suspect Pro Sports Therapy, Inc. has compromised your protected health information, you are urged to immediately contact the following:

Donald Worden, PT
Pro Sports Therapy, Inc.
Privacy Officer, Waltham Office
Office Phone: (781) 487-9944
William Harrington, PT
Pro Sports Therapy, Inc.
Privacy Officer, Westford Office
Office Phone: (978) 392-0483

Susan Rhodes, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
Government Center
J.F. Kennedy Federal Building – Room 1875
Boston, Massachusetts 02203
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818 Web Site: www.prosportstherapy.net TDD: (800) 537-7697 Email: ocrmail.hhs.gov

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I have been presented with Pro Sports Therapy, Inc.'s Notice of Privacy Practices, 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 health information:

____

____. Further, I permit a copy of this Notice 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.

Signature: ____ Date: ____________________

Signature of Legal Representative: ____________________________ Date: ____________________ (If Applicable)

Account #: ___________

PRO SPORTS THERAPY, INC.

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

As a patient of Pro Sports Therapy, Inc., you have the right to know how we may use and disclose your health information. Information about our disclosures is provided in our Notice of Privacy Practices. 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 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:

_______ 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 INFORMED 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 this Authorization to Use and Disclose Protected Health Information will take effect on the date I sign it and it will expire upon my discharge from Pro Sports Therapy, Inc. I may, in writing, revoke or modify this Authorization at any time. I understand treatment, payment, enrollment in a health plan, or eligibility for certain health benefits cannot be conditioned on my providing this authorization.

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

Signature: ______________________ Date: ______________________

Signature of Legal Representative: ______________________ Date: ______________________
(If Applicable)

840 Winter Street, Waltham MA, 02451 Tel: (781) 487-9944 Fax: (781) 487-9966
334 Littleton Road, Westford, MA 01886 Tel: (978) 392-0483 Fax: (978) 392-0947