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

Dear Patient,

Thank you for choosing Pro Sports Therapy. Enclosed is the paperwork we need you to complete and bring to your upcoming physical therapy evaluation appointment. Please arrive at least 15 minutes early to complete the registration.

In additional to the paperwork, please also bring with you the following items, in order to be seen for your appointment:

- Prescription from your physician dated within 30 days of your evaluation appointment
- Government issued picture identification
- Insurance ID card(s)
- Insurance referral/authorization if your insurance plan requires one
- All out of pocket expenses that you are responsible for, such as co-pay, co-insurance, deductible, etc.
- Loose fitting clothing or gym clothes

As a courtesy, we will call your insurance company to verify outpatient PT coverage and benefit once you provide us with all the insurance information we need. We ask that you call the insurance company to verify your own coverage and benefit as well.

If you need to cancel or reschedule your appointment, please be advised that we require at least 24 hours' notice. We reserve the right to assess a $25.00 fee for any no-show or late cancellation.

Please always check in with our front desk staff before entering the clinic area for all your appointments.

If you have any questions, please feel free to give us a call. Thank you!

Sincerely,

Pro Sports Therapy

☐ 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

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:		Provider Services Telephone:	
Street Address:	City:	State:	Zip:

****Subscriber's*** Name:	Subscriber's Date of Birth:
Insurance Group Number:	Insurance I.D. 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.

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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 you, as the patient, have failed to provide P.S.T. with your correct and current insurance information, you will be held financially responsible for the denied claim(s).

INSURANCE BENEFIT: It is your responsibility to verify, with your insurance company, coverage of physical therapy benefits. As a courtesy, P.S.T. will also verify your coverage for physical therapy services. 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 an authorization and/ or referral, you are responsible to provide that authorization and/ or referral at the time of your initial visit, and as needed to continue your treatment. You are responsible to keep track of your visits as not to exceed the number of visits authorized on the authorization and/ or referral, and to not go beyond the expiration date. You will be responsible for any visits that are not covered by the authorization and/ or referral.

MEDICAL NECESSITY: Your insurance will only pay for the physical therapy services that it considers to be medically necessary. Medical necessity is to be established by the referring physician(s) and the treating therapist(s). If your insurance determines that the physical therapy services you receive are not medically necessary, and therefore denies the claims, you will be held responsible for the denied claims. 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.

WORKERS' 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 workers' compensation 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. However, should your insurance company delay payment, pend payment, or deny payment beyond sixty (60) days of claim submission, you will be responsible for payment in full to P.S.T. within thirty (30) days of notification of the denial, from the insurance company or from the P.S.T. billing department.

DEDUCTIBLE, CO-INSURANCE & CO-PAYMENT: You hereby agree to pay all deductible, co-insurance, and co-payment obligations, as determined by your insurance carrier, 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. 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: P.S.T. requires twenty-four (24) hour notice to cancel an appointment. Should you cancel an appointment less than twenty-four (24) hours before your scheduled appointment, or fail to appear for a scheduled appointment without notice, a twenty-five dollar ($25.00) late cancellation/ no-show fee will be assessed.

PREVIOUS TREATMENT: It is your responsibility to inform P.S.T. if you have received medical treatment elsewhere, for the same or other injuries, within twelve (12) months of seeking treatment at P.S.T. Previous treatment may affect your insurance coverage of physical therapy services. It is also your responsibility to determine the availability of your physical therapy benefit from your insurance company. You will be responsible for any charges that are rejected by your 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 yes, please provide detailed information regarding previous treatment, if any, in the patient history questionnaire. ***

PATIENT STATEMENTS: All bills are payable within thirty (30) days of receipt. Failure to respond to our patient statements after sixty (60) days will result in your account being forwarded to a collection agency and a twenty-five dollar ($25.00) collection fee will be assessed. Your credit rating may 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.

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

Name: _____ Account #: _____

I _____ consent to: the use or disclosure of my "protected health information" (PHI) as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA); and this Consent by Pro Sports Therapy, Inc. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct the health care operations of Pro Sports Therapy, Inc.. I understand that diagnosis or treatment of me at Pro Sports Therapy, Inc. may be conditioned upon my consent as evidenced by my signature on this document.

My "protected health information" means health information, including but not limited to my demographic information, collected from me and created or received by my physician, physician assistant, medical assistant, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe such information may identify me.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or the healthcare operations of Pro Sports Therapy, Inc.. Pro Sports Therapy, Inc. is not required to agree to any restriction that I may request. If, however, Pro Sports Therapy, Inc. agrees to any restriction requested by me, such restriction shall be binding on Pro Sports Therapy, Inc.. I further understand that I have the right to revoke this consent, in writing, at any time, except to the extent that Pro Sports Therapy, Inc. has taken action in reliance on this Consent.

I understand that I have a right to review Pro Sports Therapy, Inc.'s **Notice of Health Information/ Patient Privacy Practices** prior to signing this Consent. Pro Sports Therapy, Inc.'s Notice of Health Information/ Patient Privacy Practices has been provided to me and describes the types of uses and disclosures of my protected health information that may occur in my treatment, payment of my bills, or in the performance of the health care operations of Pro Sports Therapy, Inc.. This Notice of Health Information/ Patient Privacy Practices also describes my rights and Pro Sports Therapy, Inc.'s duties with respect to my protected health information.

Please also note that as provided in Pro Sports Therapy, Inc.'s Notice of Health Information/ Patient Privacy Practices, Pro Sports Therapy, Inc. reserves the right to change the privacy practices that are described in such notice. I may obtain a revised Notice of Health Information/ Patient Privacy Practices by calling Pro Sports Therapy, Inc's Waltham office at (781) 487-9944, or, Pro Sports Therapy, Inc.'s Westford office at (978) 392-0483 and requesting a revised copy be mailed to the location of my choice, or by asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

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□ 334 Littleton Road, Westford, MA 01886 Tel: (978) 392-0483 Fax: (978) 392-0947

PRO SPORTS THERAPY, INC. (PST)

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 ACCESS 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 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; and
- 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; 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 Pro Sports Therapy, the information belongs to you. You have the right to:

- Obtain a paper copy of this Notice 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.

PRO SPORTS THERAPY, INC. (PST)

NOTICE OF HEALTH INFORMATION/PATIENT PRIVACY PRACTICES

(Continued)

Name: _____ Account #: _____

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
Web Site: www.prosportstherapy.net

U.S. Department of Health & Human Services
Region I- (CT, ME, MA, NH, RI, VT)
Peter Chan, Regional Manager, Office for Civil Rights
U.S. Department of Health and Human Services
Government Center
John F. Kennedy Federal Building Room 1875
Boston, Massachusetts 02203
Voice Phone: (617) 565-1340
TDD: (617) 565-1343
Facsimile: (617) 565-3809
Web Site: www.HHS.gov

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION/ PATIENT PRIVACY PRACTICES

I have been presented with Pro Sports Therapy, Inc.'s Notice of Health Information/ Patient 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 medical 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.

Signed: _____ Date: _____

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AUTHORIZATION TO USE AND DISCLOSE PATIENT INFORMATION

Account #: _____ Name: _____

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:

   Primary Care Provider: _____
   I authorize PST to send my evaluation and progress notes to the provider listed above.

   Other Health Care Provider: _____

   Family Member: _____

   Legal Representative/Health Care Proxy: _____

   Other: _____

   _____

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 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 for this injury ? ☐ 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 in past 12 months:

☐ 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.? ☐ Internet search ☐ Primary Care Provider ☐ Specialist ☐ Word of mouth ☐ Patient in the practice ☐ Hospital ☐ Insurance company ☐ NEPTN ☐ 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)

High Blood Pressure?	☐ NO	☐ YES	Height:	Weight:
Asthma?	☐ NO	☐ YES	Pregnancy? ☐ N/A ☐ NO ☐ YES	Due date:
Lung/Breathing?	☐ NO	☐ YES		
Heart condition?	☐ NO	☐ YES		
Allergies?	☐ NO	☐ YES		
Cancer?	☐ NO	☐ YES	Location:	Any treatment?
Diabetes?	☐ NO	☐ YES	Type:	Insulin dependent: ☐ NO ☐ YES
Epilepsy/Seizure?	☐ NO	☐ YES	Type of seizure:	
Osteoporosis?	☐ NO	☐ YES	Location:	Bone density testing: ☐ NO ☐ YES
Arthritis?	☐ NO	☐ YES	Location:	
Musculoskeletal	☐ NO	☐ YES	Type/Location:	
Problems?			Type/Location:	
			Type/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 condition not listed above:

Please list all current medications, including prescription, over-the-counter, herbals, vitamin/mineral/dietary supplements.
☐ Check this box if attaching a separate sheet for medications

Name of medications:	Dosage:	Frequency and how you take it:

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

PATIENT MEDICATION LIST

Account #: **Date:**

Patient Name:	**Age:**	**Sex:**
Please list all current medications, including prescription, over-the-counter, herbals, vitamin/mineral/dietary supplements.		

Name of medications:	Dosage:	Frequency and how you take it: