NEEDHAM PHYSICAL THERAPY
304 Chestnut Street
Needham, MA 02492

LAST NAME _____ **FIRST NAME** _____

PATIENT'S ADDRESS _____

TOWN/CITY_____ **STATE**_____ **ZIP CODE**_____

DATE OF BIRTH _____ **GENDER** _____

HM PH _____ **CELL PH** _____ **EMAIL** _____

I would like to receive emails about current events and updates in regard to Needham PT
YES_____ NO_____

REFERRING DOCTOR _____

MD'S ADDRESS _____

REFERRING MD'S PH _____ **FAX** _____

PRIMARY CARE PHYSICIAN _____

PCP's ADDRESS _____

PCP's PH _____ **FAX** _____

HOW DID YOU HEAR ABOUT US _____

*****HAVE YOU CALLED YOUR PRIMARY CARE PHYSICIAN FOR AN INSURANCE REFERRAL?*****
*****This is NOT the same as your prescription!*****
(Required for Aetna HMO, BCBS HMO, Cigna HMO, GIC, Mass Health and Tufts)

YES _____ **NO** _____

AUTO ACCIDENT INFORMATION

CAR INSURANCE COMPANY: _____

ADJUSTORS NAME: _____

ADJUSTORS PHONE: _____

DATE OF ACCIDENT: _____

INSURED'S NAME: _____

****CLAIM NUMBER:** _____

(MUST HAVE CLAIM NUMBER TO BE TREATED)

ATTORNEY INFORMATION

ATTORNEY'S NAME: _____

ATTORNEY'S ADDRESS: _____

CITY/TOWN: _____ **STATE:** _____ **ZIP CODE:** _____

ATTORNEY'S PHONE: _____ **FAX:** _____

NEEDHAM PHYSICAL THERAPY

MEDICAL HISTORY FORM

Current Illness:

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

When did this condition begin?

What treatment or tests have you already received (include x-rays, MRI)?

Please list all medications that you are currently taking:

Please list all past surgeries:

Past Medical History:

Please indicate whether you have had the following conditions:

Cancer (explain): _____
Heart Disease: _____
Arthritis: _____
High Blood Pressure: _____
Bleeding Tendency: _____
Diabetes: _____
Stroke: _____
Epilepsy/Seizure Disorder: _____
Kidney/Bladder Problem: _____
Osteoporosis/Osteopenia: _____
Pneumonia/Emphysema: _____
Asthma/ Respiratory Disease: _____
Hepatitis: _____
Hernia: _____
Vertigo/Dizziness: _____
Active Infection: _____
OTHER: _____

Do you have a pacemaker? Yes No
Do you have any surgical implants? Yes No
Females - Are you pregnant? Yes No

NEEDHAM PHYSICAL THERAPY

Patient Name: _____

Parent/Legal Guardian Name: _____

Consent

I, the undersigned, voluntarily authorize Needham Physical Therapy to administer physical therapy services that are necessary and appropriate in the opinion of the referring physician and/or allied health professional. Physical therapy is not an exact science and no guarantee has been made to the result of any treatment administered.

Signature: _____ Date: _____

By signing this, I acknowledge that that I have reviewed this consent authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations. I agree to the Practice's use and disclosure of my protected health information for treatment, payment and health care operations of the Notice of Protected Health Information Practices of Needham Physical Therapy.

Signature: _____ Date: _____

Be advised: **COPAYMENT IS DUE AT THE TIME OF SERVICE!**

AUTHORIZATION TO PAY NEEDHAM PHYSICAL THERAPY

I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO NEEDHAM PHYSICAL THERAPY AND I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES. I ALSO AUTHORIZE NEEDHAM PHYSICAL THERAPY TO RELEASE ANY INFORMATION TO PROCESS THIS CLAIM.

SIGNED: _____ DATE: _____

NEEDHAM PHYSICAL THERAPY

Attendance Policy

The staff at Needham Physical Therapy strives to provide the highest quality of physical therapy, education and consultation so our patients can achieve their goals. We make every effort to be consistently on time with our appointments and give each patient the individual time they deserve. In order to be successful, we ask that you agree to the following attendance policy:

1. Please give ample notice if you need to cancel an appointment. We appreciate at least **24** hours when possible, but do understand emergencies happen. Please call and we will be happy to reschedule your appointment.

2. Missed appointments (*without notice*) will result in a **$35 "no show" fee**. Two (2) or more missed appointments may result in discontinuation of your physical therapy. If you are discharged you will need a new prescription from your physician to resume. Any "no show" fees will be collected prior to reinitiating treatment.

3. Failure to schedule appointments for a period of greater than two (2) weeks may result in discontinuation of therapy services. If you are discharged you will need a new prescription from your physician to resume.

4. In order to achieve your therapy goals, it is important that you attend appointments regularly. The more consistent you are the better outcome you will achieve. More than four (4) unexplained cancellations in a month could result in discharge from physical therapy.

We appreciate your understanding and look forward to working together with you!

My signature certifies I have read and agree with the terms of the attendance policy.

_____ _____

Signature Print Name

A copy of this policy will be provided to you at any time upon request.

NOTICE OF LIEN FOR SERVICES (G.L. CH 111, 70B)

Notice is hereby given, pursuant to G.L. Chapt. 111, Sec 70B, that Needham Physical Therapy LLC, a medical services company having principal place of business at 304 Chestnut Street in Needham, MA, has provided services to the below named person injured in an accident which occurred on or about the date specified below, for which services that said Needham Physical Therapy LLC, has a lien for the reimbursement of said services upon any amount paid to said injured person, his heirs, or legal representative.

To the best of the knowledge of Needham Physical Therapy, the following information is correct, pursuant to G.L. Chapt. 111, Sec 70B. Please inform Needham Physical Therapy if you have any knowledge of any facts leading you to believe that said knowledge is incorrect.

1) Name of injured person: _____

2) Address of injured person: _____

3) Date of accident: _____

4) Name of attorney: _____

5) Name and address of
Patient's insurance carriers: _____

_____
Patient Signature

_____
Michael Kane, Owner
Needham Physical Therapy LLC

Needham Physical Therapy
Patient referral and benefit policy

All patients are responsible for contacting their insurance company to find out if they need a referral or authorizations in order for their physical therapy treatment to be covered. In the case that the patient fails to obtain the necessary authorization the patient will be responsible for their payment. It is also the patient's responsibility to inform us of any change in insurance during their time of being treated here.

It is the patient's responsibility to contact their insurance company to inquire about the out of pocket expenses the patient might incur due to physical therapy treatment. The amount quoted by the staff at Needham Physical Therapy is just an estimate based on the type of insurance plan and not a guarantee of benefits. The patient must call their insurance company to see if a copayment or deductible applies. Any out of pocket expenses incurred, based on your insurance contract, will be the responsibility of the patient regardless of whether they were aware of the cost prior to treatment.

If the insurance requires a patient to pay a large sum out of pocket and they are having trouble understanding their balance, the patient can contact **Doreen at 617-523-2766** and she will be happy to go over the expenses with you. If the patient is unable to pay their balance in full we will be happy to work out a payment plan.

Signature:_____ Date: _____