



**Elite Physical & Aqua Therapy Center**

235 Newbury Street (Route 1 North) ♦ Danvers, MA 01923

Phone: (978) 774-3888 ♦ Fax: (978) 774-2992

Website: [www.Elite-PhysicalTherapy.com](http://www.Elite-PhysicalTherapy.com)

Appt Date: \_\_\_\_\_

Appt Time: \_\_\_\_\_

**PATIENT INFORMATION FORM** Please fill out entire form, if a section does not apply, please write N/A

Patient Name: \_\_\_\_\_  
First Middle Last

Address: \_\_\_\_\_  
Street City State Zip

Social Security # (Optional): \_\_\_\_\_ Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Cell #: \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Ext \_\_\_\_\_

Email: \_\_\_\_\_ Fax #: \_\_\_\_\_

**How did you hear about Elite Physical Therapy? Please indicate below:**

Primary Care Physician  Referring MD  Friend  Past / Current Patient  Self  Other: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of Next Appointment with Referring or Primary Physician: \_\_\_\_\_

**Person to Notify IN CASE OF AN EMERGENCY**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Cell #: \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Ext \_\_\_\_\_

**INSURANCE INFORMATION**

Is this **INJURY** a result of a **WORKERS COMPENSATION** or **MOTOR VEHICLE / ACCIDENT CASE**? YES  NO   
➔ If **YES**, please list corresponding insurance company as **PRIMARY** & also list your personal health insurance company as **SECONDARY**. If **NO**, please list your personal health insurance(s) in the indicated section(s).  
Other information for **WORKERS COMPENSATION** or **MOTOR VEHICLE / ACCIDENT CASE** is continued on **PAGE 2**.

**PRIMARY INSURANCE** Co: \_\_\_\_\_ Phone: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_  
First Middle Last

Policy Holder's Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Policy Holder's Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer's Address: \_\_\_\_\_  
Street City State Zip

**SECONDARY INSURANCE**? YES  NO

Name of **SECONDARY** Insurance Co: \_\_\_\_\_

**INSTRUCTIONS FOR COMPLETION OF PAGE 2:**

Please check all that apply for questions 1 through 3 and sign and date at the bottom of this page (even if you've checked 'No' for all questions, we still require a signature for confirmation.) Thank you.

**1) IS THIS A WORKER'S COMPENSATION CLAIM? YES  NO**

Date of Injury: \_\_\_\_\_

Company Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Phone #: \_\_\_\_\_ Claim #: \_\_\_\_\_

Adjuster Name: \_\_\_\_\_

**2) IS THIS AN ACCIDENT CASE? VEHICLE: YES  NO  OTHER: NO  YES : \_\_\_\_\_**

Date of Injury: \_\_\_\_\_

Insurance Company to Bill: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Phone #: \_\_\_\_\_ Claim #: \_\_\_\_\_

Adjuster Name: \_\_\_\_\_

**3) IS THERE AN ATTORNEY INVOLVED IN YOUR CASE? YES  NO**

Attorney's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

I hereby authorize **Elite Physical Therapy, Inc.** to furnish information to the insurance carriers concerning my treatment and hereby assign to the therapist(s) all payment for services rendered. I understand that I am responsible for all charges, even those not paid by my insurance. I understand that by signing I am giving my permission for treatment. I also authorize **Elite Physical Therapy, Inc.** to contact the insurance commissioner on my behalf, to assist me in receiving my full insurance benefits, if deemed necessary.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
Patient, Parent/Guardian, or Authorized Representative of Patient

Date of current injury / onset: \_\_\_\_\_

**1)** Have you been treated at a different physical therapy clinic previously? YES  NO

If YES, what clinic did you receive treatment at? : \_\_\_\_\_ Was it for the same injury? YES  NO

**2)** Have you had any surgeries? YES  NO

If YES, Please specify (including dates if possible): \_\_\_\_\_

**3)** Have you experienced any joint, bone, muscle, cartilage, or ligament problems in the past? YES  NO

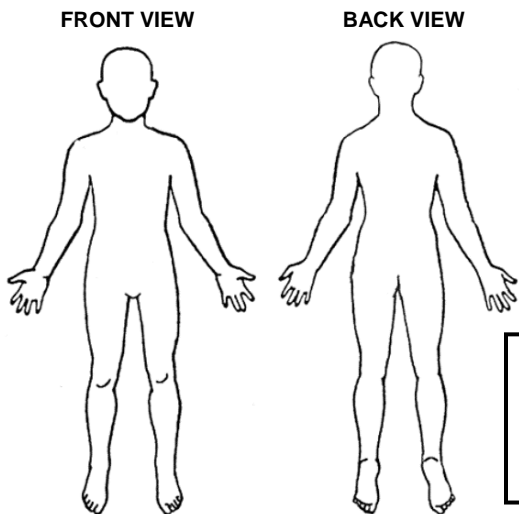
If YES, Please specify: \_\_\_\_\_

**4)** Are you pregnant? YES  NO  If YES, when is your due date? : \_\_\_\_\_

**5) Do you have or have you had any of the following? Please check all that apply:**

	YES	NO	If YES, Please list anything about the indicated condition we should be aware of
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes / Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest Pain / Angina	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	_____
Headaches / Neurological Issues	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dizziness / Fainting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke / CVA	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nausea / Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Liver / Gallbladder Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bowel / Bladder Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma / Breathing Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	_____
OTHER	<input type="checkbox"/>	<input type="checkbox"/>	_____

**6)** Please use the **SYMPTOMS KEY** to indicate areas of concern:



**SYMPTOMS KEY:**  
 Numbness: zzzzzz  
 Tingling: +++++  
 Soreness: ssssss  
 Burning Pain: xxxxxx

**7)** Please list any medications you are currently taking:  
 (If you have a list written, it can be copied & attached)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**TO OUR VALUED PATIENTS:**

We are committed to providing you with the best possible care. If you have medical insurance it is our goal to ensure your maximum allowed benefits. In order to do this we need to explain to you how our payment policy works. Depending on your specific health insurance plan, you may or may not be responsible for a balance. If you are not clear on your benefit coverage and what you may be responsible for, please discuss any and all concerns with the patient representative who will gladly help you obtain that information. It is our goal to make sure you fully understand this billing process. Payment for services is due on each visit for charges incurred up through your last visit. We accept cash, checks, American Express, MasterCard, or Visa. We bill electronically, to expedite payment of claims. If you have an insurance that requires a paper claim to be completed, we will gladly mail the form along with the claim.

**Please read carefully:**

1. Your insurance is a contract between you, your employer and your insurance co. We are not a party to that contract. You will either have insurance with a co-payment, a deductible/co-insurance or no insurance at all. Any percentage of payment not covered or paid through your insurance for any reason will be your financial responsibility. If you have no insurance you will be solely responsible for your visits.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of U.C.R. "U.C.R." is defined as usual, customary and reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. These particular services, if any, are your responsibility and will be made aware to you.
4. If this injury is work related, and a Workers Compensation claim has been initiated, it is your responsibility to provide us with all the billing information. If you already have a claim number, please provide us with the number on the registration form along with your attorney information if you have one. We also require, on your initial visit, that you provide us with your medical insurance to insure payment of the account. If there is a denial for any reason, your health insurance will then be billed. Without this information you will be financially responsible.
5. For liability cases, where another party is responsible, you need to provide us with all the billing information. If you already have a claim number, please provide us with the number on the registration form along with your attorney information if you have one. It is this office's policy that you sign the letter of protection included with paperwork which you complete at your initial evaluation. We also require, on your initial visit, that you provide us with your medical insurance to insure payment of the account. If there is a denial for any reason, your health insurance will then be billed. Without this information you will be financially responsible.
6. Our office requires a 24-hour notice for cancellation of appointments; you can call and leave a message on the answering machine if needed. We realize conflicts with work, other activities, or unexpected illness may require you to call and reschedule, however, there will be a \$25.00 charge for a missed appointment without notification to the office.

Again, our relationship is with you, not your insurance company. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage please contact our patient representative. We are here to help you with this process!

**I have read the above policies and agree.**

<b>Signature:</b> _____ <b>Date:</b> _____ Patient, Parent/Guardian, or Authorized Representative of Patient
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PHYSICAL THERAPY & AQUA THERAPY CENTER

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

NOTE TO PATIENT:
A signed authorization form is required by some healthcare providers & attorneys to have permission by the patient to legally release any requested documentation to our clinic; i.e., Radiology Reports, MRI Reports, Operative Reports, & other related documentation.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_
First Last

Maiden Name: \_\_\_\_\_ Social Security: \_\_\_\_\_
(If Applicable)

I herein authorize Elite Physical Therapy, Inc. the right to obtain and receive the following information:

(Please check the following documents / reports authorized to be obtained)

- X-Ray Images / Radiology Reports / MRI Reports
Surgical / Operative Reports (recommended to be authorized if you are a post-operative patient)
Office Visit Chart Documentations
Treatment & Discharge Summaries from previous physical therapy clinic(s) (if applicable) and or hospital / emergency room visits
Other: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_
Patient, Parent/Guardian, or Authorized Representative of Patient

# NOTICE OF PRIVACY PRACTICES

## Patient Acknowledgement

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Please review this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, and the practice's legal duties with respect to my protected health information. The notice includes:

- ✓ A statement that this practice is required by law to maintain the privacy of protected health information.
- ✓ A statement that this practice is required to abide by the terms of the notice currently in effect.
- ✓ Types of uses and the disclosures that this practice is permitted to make for each of the following purposes: Treatment, payment, and health care operations.
- ✓ A description of each of the other purposes for which this practice is permitted to use or disclose protected health information without my written consent or authorization.
- ✓ A description of use and disclosure that are prohibited or materially limited by law.
- ✓ A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- ✓ My individual rights with respect to protected health information and a brief description of how I may exercise these rights to relation to:
  - The right to complain to this practice and to the Secretary of HHS if I believe that my privacy rights have been violated and that no retaliatory actions will be used against me in the event of such a complaint.
  - The right to request restriction on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice has the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that is maintains. I have read & understood this practice's current Notice of Privacy Practices.

<b>Signature:</b> _____	<b>Date:</b> _____
Patient, Parent/Guardian, or Authorized Representative of Patient	



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# ATTENDANCE POLICY

## PLEASE READ & INITIAL THE FOLLOWING:

- 1) Elite requires a 24 hour notice prior to the cancellation or reschedule of any appointments.  
(Excluding: emergencies, serious illness, & poor weather conditions).



**Initial:** \_\_\_\_\_

- 2) Elite reserves the right to cancel any scheduled appointments due to frequent cancellations & rescheduling. Please note that this will be communicated to you prior to cancelling if attendance does become an issue. Appointments may be scheduled only one at a time rather than a full two weeks out.



**Initial:** \_\_\_\_\_

- 3) Elite has no tolerance for no-showing to scheduled appointments. We understand mistakes can occur, but more than one no-show may result in the cancellation of all scheduled appointments.



**Initial:** \_\_\_\_\_

Exceptional care is our goal and we strive to make it possible for all patients to maintain appointments and achieve an optimal level of health. Because our patients truly value their physical therapy program, we ask that you please honor our **attendance policy**. This allows us to accommodate our patients' needs and we appreciate your consideration in this matter.

**Please sign below to confirm you've acknowledged & comprehended all aspects of this policy.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Patient, Parent/Guardian, or Authorized Representative of Patient