



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

Patient ID Number

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: _____

INSURANCE INFORMATION (CONTINUED)

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.

Patient Name: _____

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

- c. YES NO--Do you have angina (chest pain) or circulation problems?
- d. YES NO--Do you have seizures/neurological issues/stroke/CVA? (circle)
- e. YES NO--Do you experience shortness of breath or have asthma? (circle)
- f. YES NO--Do you have lung disease/kidney/liver/gallbladder problems? (circle)
- g. YES NO--Do you have heartburn/stomach upset/nausea/vomiting/ulcers? (circle)
- h. YES NO--Have you experienced recent weight loss/gain? (circle)

Patient Name: _____

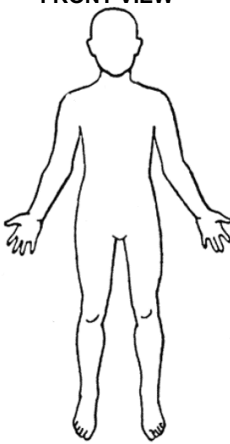
- i. YES NO--Do you have a thyroid condition?
- j. YES NO--Do you have diabetes or low blood sugar? (circle)
- k. YES NO--Do you have a history of cancer? List type _____
- l. YES NO--Do you have osteoporosis?
- m. YES NO--Do you have a history of fractures or joint/ligament/muscle injury? (circle)
- n. YES NO--Have you had an increase in frequency or intensity of headaches?
- o. YES NO--Do you have impaired vision or hearing? (circle)
- p. YES NO--Do you have any problems with bowel or bladder function? (circle)
- q. YES NO--Do you have HIV/AIDS/MRSA? (circle)
- r. YES NO--Do you smoke?
- s. YES NO--Do you have dizziness/ ringing in the ears/fainting? (circle)
- t. YES NO--Do you have a Hernia?
- u. YES NO--Do you have Hepatitis?

WOMEN:

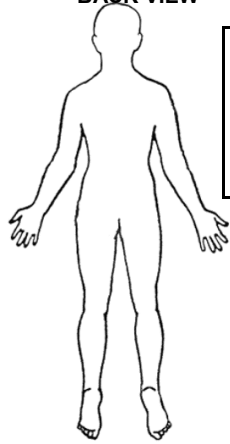
- 1. YES NO--Are you or do you suspect pregnancy? Due date _____
- 2. YES NO--Have you had any complicated pregnancies?
- 3. YES NO--Do you have dysmenorrhea (abnormal menstrual cycles)?
- 4. YES NO--Have you had pelvic inflammatory disease or Endometriosis (circle)

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

FRONT VIEW



BACK VIEW



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)

Signature: _____
Date: _____

Patient Name: _____

PHYSICAL THERAPY FINANCIAL POLICY

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 emergencies happen; 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.

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



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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 it maintains. I have read & understood this practice's current Notice of Privacy Practices.

Signature: _____ Date: _____ <div style="text-align: center; font-size: small;">Patient, Parent/Guardian, or Authorized Representative of Patient</div>



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ATTENDANCE POLICY

PLEASE READ & INITIAL THE FOLLOWING:

- 1) Elite requires 24 hours notice prior to the cancellation or reschedule of any appointment. (Excluding: emergencies, serious illness, & severe weather conditions). If you cancel without 24 hours notice you will be charged \$25 that must be paid on your next visit.



Initial: _____

- 2) If you are more than 15 minutes late for your scheduled appointment, we reserve the right to cancel the appointment per the therapist's discretion.



Initial: _____

- 3) Elite has no tolerance for not-showing to scheduled appointments. We understand oversights do occur, which is why there is no penalty for the first no-show; however, there will be a \$25 charge for every no-show after. The \$25 must be collected on your next visit.



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

Patient Name (Print): _____

Signature: _____ Date: _____

Patient, Parent/Guardian, or Authorized Representative of Patient