FRANKLIN•HANOVER•MARSHFIELD
PHYSICAL THERAPY

Marshfield Physical Therapy Webster Square Suite 10 Marshfield, MA 02050	Hanover Physical Therapy 272 Columbia Road, # 4 Hanover, MA 02339	Franklin Physical Therapy 473 West Central Street Franklin, MA 02038

Patient Information Form

(Please print legibly)

Name: _____ Sex: Male / Female Date of Birth: _____

Mailing Address: _____ City: _____ Zip: _____

Primary Phone #: (circle one: Cell/Home/Work) _____

Cell Phone Provider(Verizon, AT&T, etc): _____

Secondary Phone #: (circle one: Cell/Home/Work) _____

Email Address: _____

Occupation: _____ Employer Name: _____

Primary Doctor:

Practice and Location (town): _____

Phone #: _____

Referring Doctor: (if different)

Practice and Location (town): _____

Phone #: _____

How did you hear about us? (circle one) Friend Family Physician Internet Sign/Ads

Whom may we thank for referring you to us? _____

Emergency Contact:

Name: _____ Relationship: _____

Phone: _____

Responsible Party/Guardian: *(needed only if patient is a minor)*

Name: _____ Relationship: _____

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Address: (if different) _____ City: _____ Zip: _____

Phone #: (circle one: Cell/Home/Work) _____

Email Address: _____

Accident/Injury Information

Is your injury due to an On-The-Job injury or a Motor Vehicle Accident? YES / NO

If yes, check appropriate box:

☐ On-The-Job ☐ Motor Vehicle

Date of the accident/injury: _____

Insurance Company:_____ Claim Number: _____

Address: _____

Adjuster: _____ Phone Number: _____

Personal Insurance Information

Name of Policy Holder: _____ Insurance ID#: _____

Policy Holder Date of Birth: _____ Insurance Group #: _____

Relationship to Patient: _____ Plan Type/Name: _____

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General Medical History

1. Current level of pain, on a scale of 0 to 10 (0= no pain, and 10 = worst pain imaginable)

   _____

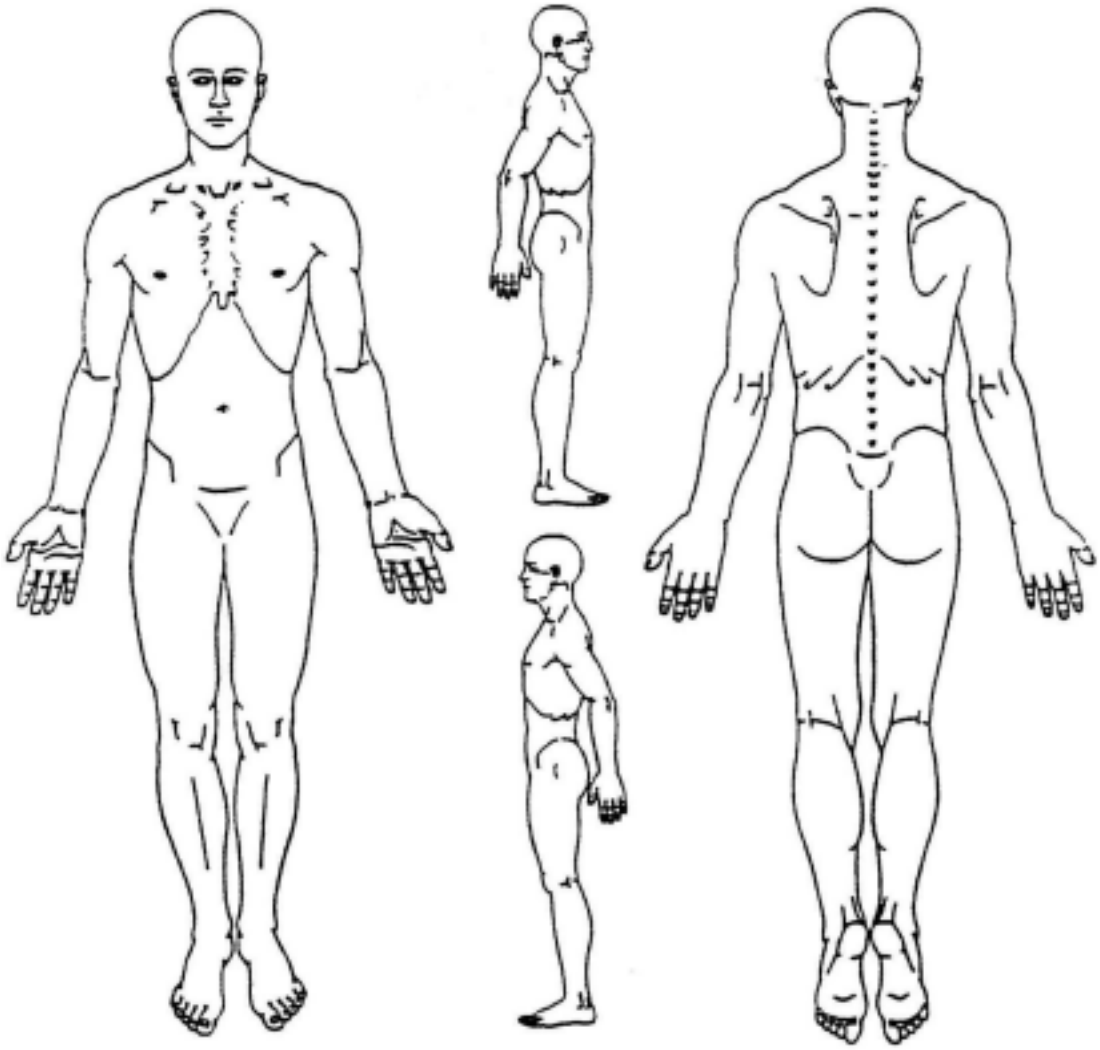
2. Score your current ability to perform simple movements with your involved region (0 = normal movement, and 10 = unable to move your involved region at all.)

   _____

3. Function: Score your ability to perform your activities of daily living (getting out of a bed or chair, driving, getting dressed, etc.) (0 = able to perform ALL normal activities, and 10 = unable to perform ANY of your normal daily activities.)

   _____

Please Mark the Area of Symptoms Below:



Are you currently working? (Please circle one) YES / NO

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Type of work: _____

If not, why not?: _____

Please check (X) if you have had problems with or been treated for:

- ☐ **Heart Problems**
- ☐ **Fainting or dizziness**
- ☐ **Shortness of Breath**
- ☐ **Calf Pain with Exercise**
- ☐ **Severe Headaches**
- ☐ **Recent Accident**
- ☐ **Head Trauma/Concussion**
- ☐ **Muscular Weakness**
- ☐ **Cancer**
- ☐ **Joint Dislocation(s)**
- ☐ **Broken Bone**
- ☐ **Difficulty Sleeping**
- ☐ **High Blood Pressure (Hypertension**
- ☐ **Difficulty Swallowing**
- ☐ **A wound that does not heal**
- ☐ **Unusual skin coloration**
- ☐ **Lung disease/problems**
- ☐ **Arthritis**
- ☐ **Swollen and painful joints**
- ☐ **Irregular heartbeats**
- ☐ **Stomach pains and ulcers**
- ☐ **Pain with cough or sneeze**
- ☐ **Back or neck injuries**
- ☐ **Stroke(s)**
- ☐ **Muscular Pain with Activity**
- ☐ **Frequent falls**
- ☐ **Kidney Disease**
- ☐ **Liver Disease**
- ☐ **Weakness or fatigue**
- ☐ **Hernias**
- ☐ **Blurred Vision**
- ☐ **Circulatory Problems**
- ☐ **Jaw Problems**
- ☐ **Pregnancy**
- ☐ **Bowel/Bladder Problems**
- ☐ **Swollen ankles or legs**
- ☐ **Tremors**
- ☐ **Epilepsy/Seizures/convulsions**
- ☐ **Chest pain or pressure at rest**
- ☐ **Night pain while sleeping**
- ☐ **Constant pain unrelieved by rest**
- ☐ **Constant pain or pressure**
- ☐ **Nervous or emotional problems**
- ☐ **Pacemaker/implanted stimulator**
- ☐ **Unexplained weight loss**
- ☐ **Any infectious disease (TB, AIDS, Hepatitis)**

Experiencing Tingling, Numbness, or Loss of Feeling? (Please circle) YES / NO

If yes, where? _____

Allergies (Latex, Medication, Food): _____

_____

Do you use tobacco? YES / NO

If yes, how much? _____

Do you have a history of falls? (Please explain) _____

_____

Are you presently taking any medications or drugs? YES / NO

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If yes, please list all medications and the reason you are taking them:

_____

_____

_____

_____

Please list any surgeries or other conditions for which you have been hospitalized:

Date Surgery and Reason:

_____

_____

Please list any recent X-rays, CT scans or MRIs:

Date and Body Region:

_____

_____

Have you ever been evaluated and/or treated by another physician, physical therapist, chiropractor, osteopath, or health care professional for this condition? (please circle) YES / NO

If Yes, Please List:

_____

_____

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Physical Therapy Attendance Policy
(Please Read Thoroughly)

MK Rehabilitation strives to provide each patient with the highest quality of care while attempting to accommodate your schedule for your convenience. Therefore, we provide reserved time slots for each patient with a specific therapist in order to minimize your waiting and assure continuity of your treatment. Your consistent attendance of the planned treatment regimen is a paramount to your full recovery.

While we are sensitive to the fact that an emergency may occur in a rare instance, cancellations, especially last minute ones, along with patient no-shows, decrease our ability to accommodate the scheduling needs of the other patients. Additionally, no-shows display a complete lack of respect for your therapist and fellow patients. We must ask for your full cooperation with the following policy:

- If you are more than 30 minutes late for your appointment and fail to notify us, treatment may be canceled and a fee charged for missing the appointment
- A scheduled appointment MUST BE CANCELED AT LEAST 24 HOURS IN ADVANCE or a fee will be charged for that appointment
- Failure to show up for an appointment (“NO SHOW”) without notifying us will result in a fee being charged for that appointment. Furthermore, 2 consecutive no-shows will result in the cancellation of all remaining scheduled appointments.
- At week’s end, ALL PATIENTS, regardless of insurance/third party payer, will be charged a **$50 CANCELLATION FEE** for each late, late-canceled, or no-show appointment. THE PATIENT IS RESPONSIBLE FOR THE FEE, NOT THE INSURANCE/THIRD PARTY PAYER
- The credit card on file will be charged the **$50** fee the day of the no-show or canceled appointment with less than 24 hours notice
- No cancellation fee will be charged if the missed appointment is made up within the same week it was scheduled, on a day that you do not have another appointment scheduled
- All cancellations and no-shows will be documented in your medical record and appropriately reported to your physician and insurance/third party payer
- Repeated failure to comply with this ATTENDANCE POLICY will result in your name being placed on a “Schedule Based on Availability” list. This will require you to call for an open appointment on each day you would like to receive therapy. We will do everything possible to accommodate you, as space on the schedule permits.

We believe that this policy is necessary for the benefit of all our patients, so that we may continue to provide high quality treatment and services to everyone.

All of the staff at MK Rehabilitation appreciates your anticipated adherence and cooperation with this policy. We wish you the best of luck with your treatment. We are here to help you attain all of your goals and optimize your return to all of your pre-injury activities

Patient Signature: _____

Date: _____

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CONSENT TO TREAT

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient. Our policy requires payment in full for services rendered at the time of visit, unless other arrangements have been made with the business manager. If the account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand all the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

_____
(Please Initial)

NOTICE OF PRIVACY PRACTICES

Our commitment at MK Rehabilitation, LLC is to serve our customers with professionalism and care, being sure at all times to protect the privacy and security of all protected health information in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). You have the right to review that notice before you sign this acknowledgement form (§ 164.520). We encourage you to read this document carefully, for it outlines the limitations of the use and disclosure of your personal and/or health information as well as your rights as a patient. If you ever have any questions or concerns regarding the use or disclosure of your health and/or personal information we would be happy to address them.
I HAVE READ AND UNDERSTAND THE ABOVE NOTICE OF PRIVACY PRACTICES

_____
(Please Initial)

ASSIGNMENT OF BENEFITS

I understand that I am ultimately responsible for my physical therapy charges, and I agree to pay my deductible, my co-payment, and any adjustments after a co-insurance or any charges not reimbursed by my insurance carrier. I understand I am responsible for knowing and meeting the requirements of my insurance plan. I further understand that co-payments are due at the time of service and that payment of any deductibles and coinsurance are my responsibility as stated in my contract with my insurer. Any portion of these charges not covered by my insurer must be paid by me.
I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

I HEREBY AUTHORIZE PAYMENT TO BE MADE DIRECTLY TO MK REHABILITATION LLC (D/B/A Franklin/Hanover/Marshfield PHYSICAL THERAPY), FOR SERVICES RENDERED. I HEREBY AUTHORIZE MK REHABILITATION TO RELEASE (OR OBTAIN) INFORMATION REGARDING MY PHYSICAL THERAPY EVALUATION AND TREATMENT AND RELATING BILLING INFORMATION TO (FROM) MY ATTORNEY OR INSURANCE CARRIER FOR PURPOSES OF PROCESSING THIS CLAIM. WE RESERVE THE RIGHT TO CHARGE FOR APPOINTMENTS CANCELED WITHOUT A 24 HOUR NOTICE.

I HAVE READ AND UNDERSTAND THE ABOVE ASSIGNMENT OF BENEFITS

_____
(Please Initial)

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AUTHORIZATION FOR RELEASE OF INFORMATION

I HEREBY AUTHORIZE MK Rehabilitation, LLC to release my health care information including but not limited to testing, diagnosis, and/or treatment plans to my insurance company, adjuster, attorney, Workers Compensation carrier, and/or to my referring physician or any physician that assists in the administration or continuation of my plan of care.

I HEREBY AUTHORIZE any healthcare provider to release my personal health information as it pertains to my rehabilitative care if any is requested by MK Rehabilitation, LLC.

Patient Signature (Or Responsible Party): _____

Date:_____

CREDIT CARD ON FILE POLICY

Thank you for choosing MK Rehabilitation for your orthopedic and sports medicine needs. We are committed to providing you with exceptional medical care, as well as, making our medical billing processes as simple and efficient as possible. Recent shifts in the healthcare industry have resulted in insurance companies increasingly transferring costs to our patients, you, the insured. This is driving many practices to adopt new financial policies to enable more efficient operational processes. Some insurance plans require deductibles and copayments in amounts not known to you or us at the time of your visit. Please take a moment to familiarize yourself with our practice's new Credit Card on File Policy.

To streamline our billing and payment system and to provide a seamless, convenient way for patients to pay their bills, MK Rehabilitation will require all patients keep an active credit card on file with us. The credit card will be kept in a secure and HIPAA compliant vault by World Pay. We will bill your insurance company first and upon their determination of benefits, the following process will be in place:

Co-pays will remain due at each visit and can be paid in any manner you choose at that time. If you have private, motor vehicle, or workers compensation insurance we will submit your claim for you as usual.In approximately one to three weeks, you should receive an explanation of benefits(EOB)from your insurer that outlines what part of your service has been covered by your insurance and reveal exactly how much remains your responsibility to pay our practice for the services rendered. We will receive a copy of your EOB from your insurer shortly thereafter and will charge your credit card on file with the amount due as indicated. If there is no balance due, your card is not charged. A copy of the receipt can be emailed to you, or you can request a printed receipt from any front desk staff.

If the credit card we have on file for you changes, please notify us IMMEDIATELY, by calling the office at 781-834-4600. It is not uncommon for people to change or cancel their credit cards for various reasons, including when a credit card expires. We will contact you or leave you a phone message on the phone number you provided for us, asking you to give us a call with the new number. We will enter the new credit card number into your file, and that will become your new card on-file, subject to the same financial policy as the card you gave us in-person when you were in our office. If there is a problem with your bill/claim and it is brought to our attention after your credit card payment processes, we will investigate it and if we owe you the money, we will refund it to the same card in a timely manner.

We understand that there are legitimate reasons that you may not have a credit card. If this is the case, you are welcome to leave an HSA (Health Savings Account) or Flex Plan Card on File. You may also pay

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for the visit with cash or a personal check. You may contact one of our Billing Representatives in advance if you would like an **estimate** of what your charges may be.

_____
(***please initial)***

PRE-AUTHORIZED HEALTHCARE FORM

By signing below, I agree to all of MK Rehabilitation's Credit Card on File Policy and I authorize MK Rehabilitation to keep my signature and a valid credit/debit card number securely on-file in my account. I allow MK Rehabilitation to automatically charge my credit card for any outstanding balances. These may include: insurance denials for ANY reason (including no referral on file); missed or canceled appointments; deductibles; co-insurances; partially paid claims. If the credit card that I give today changes, expires, or is denied for any reason, then I agree to immediately give MK Rehabilitation a new, valid credit card which I will allow them to key-in over the phone. Even though MK Rehabilitation is not swiping this card in person, I agree that the new card will still be subject to the financial policy listed herewith and may be used with the same authorization as the original card which I presented in person I understand that I am responsible for payment for all medical services provided to me by MK Rehabilitation. I understand that my insurance may deny or delay payment for these services or only partially pay them, and I agree to allow MK Rehabilitation to immediately charge my credit card on file for the balance if that happens. I understand that this form is valid until I cancel this authorization through written notice to MK Rehabilitation.

Signature of Patient / Credit Card Holder (or Legal Guardian):
_____ Date: _____

Relationship to Patient: _____

CONSENT TO EMAIL OR TEXT USAGE FOR APPOINTMENT REMINDERS AND OTHER HEALTHCARE COMMUNICATIONS

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/informa<on. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communica(ons/informa(on at that email or text address from the Practice.

_____
(please initial)

I consent to receive text messages from the practice on my cell phone and any number forwarded or transferred to that number or emails to receive communica(on as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is: _____.

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The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is: _____.

The prac)ce does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Revocation

I _____ hereby revoke my request for future communications via email and/or text messages. I _____hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.

Note: *This revocation only applies to communica)ons from this Practice.*

Patient Name: _____)_____
Patient/Patient Representative Signature: _____
Date: _____

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent to photographs, videotapes, digital or audio recordings, and /or images of me being recorded for security purposes and/or the prac(ce's health care opera(ons purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/ or recordings in which I am identified will not be released and/or used without a specific written authorization(on from me or my legal representative unless it is for treatment, payment or health care opera(ons purposes or otherwise permitted or required by law.

Patient Signature: _____
Date: _____