NORWOOD PHYSICAL THERAPY

49 Walpole Street, Suite 2
Norwood, MA 02062

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 Norwood 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 ___________________

PATIENT'S WORK INFORMATION

EMPLOYER'S NAME: ____

EMPLOYER'S ADDRESS: ____

CITY/TOWN: ______________ STATE: ____________ ZIP CODE: ______________

WORK PHONE: __________________ OCCUPATION: _________________________

WORKER'S COMPENSATION INFORMATION

EMPLOYER'S NAME (AT TIME OF INQUIRY): ______________________________

W/C INSURANCE COMPANY NAME: ____________________________________

W/C INSURANCE COMPANY ADDRESS: __________________________________

CITY: __________ STATE: _______ ZIP CODE: ________ PHONE: _____________

CLAIM NUMBER: ____

(Claim number required to be treated)

ADJUSTOR'S NAME: ____

PHONE: _________________________ FAX: _____________________________

ATTORNEY INFORMATION

ATTORNEY'S NAME: ____

ATTORNEY'S ADDRESS: ____

CITY/TOWN: ____________________ STATE: _______ ZIP CODE: ______________

ATTORNEY'S PHONE: ______________________ FAX: _______________________

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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

NORWOOD PHYSICAL THERAPY

Patient Name: ____

Parent/Legal Guardian Name: ____

Consent
I, the undersigned, voluntarily authorize Norwood 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 Norwood Physical Therapy.

Signature: ___________________________________ Date: ______________________

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

AUTHORIZATION TO PAY NORWOOD PHYSICAL THERAPY

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

SIGNED: ____ DATE: ______________________

NORWOOD PHYSICAL THERAPY

Attendance Policy

The staff at Norwood 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.

Norwood 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 Norwood 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: ____________________