Mass Bay SPINE & SPORT Physical Therapy, Inc.

Physical Therapy Patient Information

Today's Date: ___/___/___

Patient Name: _____ Sex: _____ DOB: ___/___/___

If minor, Name of Parent or Legal Guardian: _____

Patient Address: _____ Height: _____ Weight: _____

City, State, Zip: _____ Soc. Sec. #: _____-____-_____.

Phone (home): _____ Work: _____ Cell: _____

☐ Email address:_____ ☐

Please initial all the ways with which we can contact you with appointment & treatment information:

Phone: Home____ Work____ Cell____ Email____

Mar.Status: _____ Occupation: _____ Employer: _____

Current Work Status: ☐ FT ☐ PT ☐ Restricted Duty ☐Out of Work (since?_____)

Emergency Contact: _____ Phone: _____

Primary Care Physician? _____ Referring Physician:_____

Insurance Company:_____

Name of Insured (*if not patient*): _____ Relationship: _____

Phone: _____ DOB: ___/___/___ Soc. Sec. #: _____-____-_____.

Have you had physical therapy for any reason this year? YES NO

If yes, please explain: _____

How did you hear about us? _____

ACCIDENT INFORMATION (please check on of the following)

1. Were you injured while at work? _____ Date of injury: ___/___/___
   Have you received prior treatment? _____ If yes, name of physician: _____
   Workman's Compensation Insurance Agent: _____
   Phone number: _____ Claim #: _____
   Name of Attorney (if applicable): _____ Phone: _____
   Address:_____
   Dates out of Work: From: ___/___/___ To: ___/___/___

2. Automobile accident? _____ Date of accident: ___/___/___
   Have you received prior treatment? _____ If yes, name of physician: _____
   Automobile Insurance Carrier: _____ Claim#_____
   Name of adjuster: _____ Phone: _____
   Name of attorney (if applicable): _____ Phone: _____
   Address: _____
   State accident occurred in? _____ Who was at fault? _____
   Dates out of work: From: ___/___/___ To: ___/___/___

Mass Bay SPINE & SPORT Physical Therapy, Inc.

PATIENT MEDICAL HISTORY FORM

Name: _____

Medical History

Allergies	☐yes	☐no	Hepatitis	☐yes	☐no
Anemia	☐yes	☐no	High Cholesterol	☐yes	☐no
Anxiety	☐yes	☐no	High/Low Blood Pressure	☐yes	☐no
Arthritis	☐yes	☐no	HIV/AIDS	☐yes	☐no
Asthma	☐yes	☐no	Incontinence	☐yes	☐no
Autoimmune Disorder	☐yes	☐no	Kidney Problems	☐yes	☐no
Cancer	☐yes	☐no	Metal Implants	☐yes	☐no
Cardiac Conditions	☐yes	☐no	MRSA	☐yes	☐no
Cardiac Pacemaker	☐yes	☐no	Multiple Sclerosis	☐yes	☐no
Chemical Dependency	☐yes	☐no	Muscular Disease	☐yes	☐no
Circulation Problems	☐yes	☐no	Osteoporosis	☐yes	☐no
Currently Pregnant	☐yes	☐no	Parkinsons	☐yes	☐no
Depression	☐yes	☐no	Rheumatoid Arthritis	☐yes	☐no
Diabetes	☐yes	☐no	Seizures	☐yes	☐no
Dizzy Spells	☐yes	☐no	Smoking	☐yes	☐no
Emphysema/Bronchitis	☐yes	☐no	Speech Problems	☐yes	☐no
Fibromyalgia	☐yes	☐no	Strokes	☐yes	☐no
Fractures	☐yes	☐no	Surgeries	☐yes	☐no
Gallbladder Problems	☐yes	☐no	Thyroid Disease	☐yes	☐no
Headaches	☐yes	☐no	Tuberculosis	☐yes	☐no
Hearing Impairment	☐yes	☐no	Vision Problems	☐yes	☐no

Please provide details for any condition marked "yes" (please include surgery dates):_____
_____
_____
_____

Describe any other conditions or precautions: _____
_____

Fall History

Have you had an injury as a result of a fall in the past year? …… ☐ Yes ☐ No
Have you had two or more falls in the last year? …….. ☐ Yes ☐ No
If yes to either question, please describe: _____
_____

Current Medications

Prescription: Frequency: Dosage:

_____
_____
_____
_____
_____
_____
_____

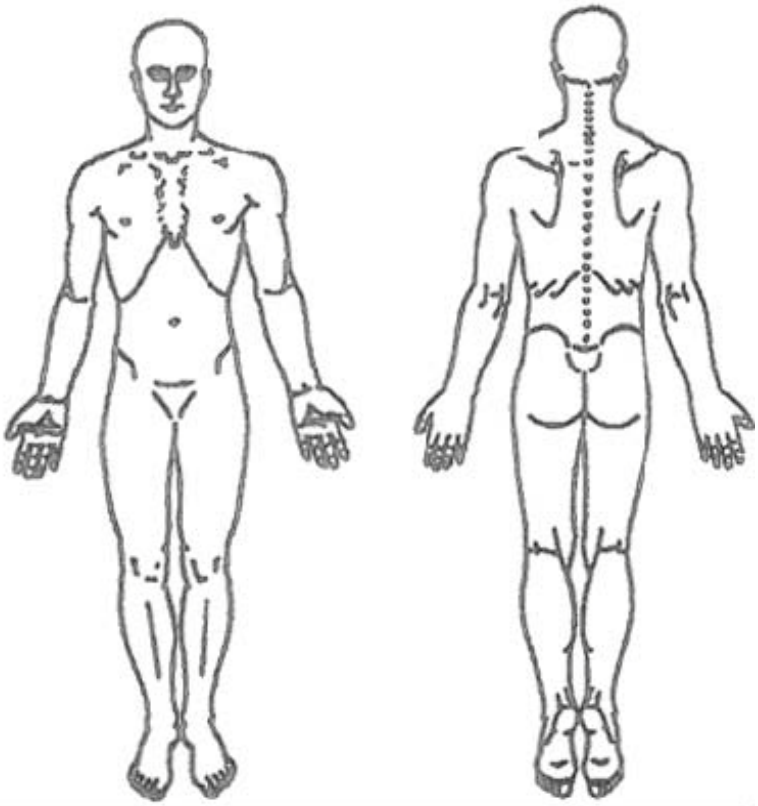
Pain and Symptom Status Report

Name: _____ **Date:** _____

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing

Ache	Burning	Numbness
MMM	— — —	O O O O
M	— —	O O O

Pins and Needles	Stabbing	Other
o o o o o o o o o	/ / / / / /	x x x x
o o o o o o o o	/ / / /	x x x



Chief Complaint and Visual Analog Scale

My Chief Complaint is: _____
Date First Symptom of your problem occurred on. _____

2nd Complaint _____

3rd Complaint: _____

Please circle on the scale below to indicate your <u>CURRENT</u> level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Pain as bad as it gets.**

Please circle on the scale below to indicate your <u>BEST</u> level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Pain as bad as it gets.**

Please circle on the scale below to indicate your <u>WORST</u> level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Pain as bad as it gets.**

Additional Comments _____

Mass Bay SPINE & SPORT Physical Therapy, Inc.

Brendan Carman, MPT, ATC
Patricia Simms, PT
Kerin Murphy, DPT
Regina Santilli, DPT
Courtney Parisot, DPT
Joel Willbrant, DPT

Phone: 781-319-0024
Fax: 781-319-0088

PATIENT MISSED APPOINTMENT POLICY

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well being and gain of your physical abilities is something everyone in our clinic takes quite seriously.

Because we care so much about you we realize that it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive and to the actions we ask you to do.

Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore we have certain rules that need to be followed in order to ensure the most optimum results.

We expect you to keep all your appointments. Write down the time of your visits so that you do not forget.

With the exception of serious emergencies it is expected that you keep all your appointments. If you need to re-schedule an appointment we require a 24 hours notice. In such a case, please call our office and arrange for a make-up appointment with our Front Desk Receptionist. The make-up appointment needs to be in the same week, preferably the very next day.

In an instance of a cancellation without 24 hours notice or no-show to a scheduled appointment, we reserve the right to charge you a $ 25 fee.

In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care and will inform your physician of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

Brendan Carman, Owner
Mass Bay Spine & Sport Physical Therapy, Inc.

I have read and understand this policy:_____ Date:_____

Print Name:_____

Mass Bay Spine & Sport Physical Therapy, Inc.

Acknowledgement of Policies

The following are Mass Bay Spine and Sport Physical Therapy Inc.'s office policies governing patient care. Please read carefully and **initial each policy** signifying your understanding and agreement to abide by said policies.

___**Appointment Scheduling**. We will strive to provide you with effective, efficient treatment and accommodate your needs to the best of our ability. To be fair to all of our patients, we ask that cancellations be made 24 hours in advance, and if you are going to be late for your appointment, please call and let us know. Adherence to the recommended plan of care and consistency with appointment attendance is vital to your progress. Please make every effort to follow this plan. Lastly, if you miss more then 3 appointments without prior notification, we reserve the right to discontinue your therapy to open the schedule to new patients. Thank you for your cooperation regarding these policies.

___**Consent to Treatment**. I voluntarily consent to physical therapy evaluation and treatment as prescribed by my attending physician or his/her designees as necessary, under the direction of a registered physical therapist/physical therapist assistant. Further, I acknowledge that no guarantee has been or can be made as to the results of such treatments.

___**Privacy Practices Acknowledgement**. We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the ***Health Insurance Portability and Accountability Act*** of 1996 (HIPPA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them. By initialing this section, I, the undersigned, acknowledge that a copy of Mass Bay Spine and Sport Physical Therapy Inc.'s ***Notice of Privacy Practices for Protected Health Information*** has been made available to me.

___**Assignment of Benefits**. In consideration of agreement between Mass Bay Spine and Sport Physical Therapy Inc. and myself to provide me with physical therapy services, I hereby irrevocably assign to Mass Bay Spine and Sport Physical Therapy Inc., my right, title, and monetary interests in, and to all, insurance benefits to which I may be entitled to. Assignment of such benefits is limited to the extent of the amount of the cost of all services to me by Mass Bay Spine and Sport Physical Therapy Inc. I hereby authorize all payment for services provided by Mass Bay Spine and Sport Physical Therapy Inc. to be paid directly to Mass Bay Spine and Sport Physical Therapy Inc. that may be due upon receipt of claims or itemized statements for services rendered.

___**Billing/Information Release.** I authorize Mass Bay Spine and Sport Physical Therapy Inc. to furnish all necessary parties any information it may have regarding my condition while under observation or treatment deemed necessary to facilitate reimbursement for services rendered. I acknowledge that Mass Bay Spine and Sport Physical Therapy Inc. is duly authorized such rights in accordance with all federal and state confidentiality laws.

___**Responsibility of payment.** I, the undersigned, acknowledge full financial responsibility to Mass Bay Spine and Sport Physical Therapy Inc. for any and all charges not covered by my insurance policy. This includes all co-pays, deductibles, or charges that are denied payment by my insurance company for services rendered.

I certify that I have read, understand, and agree to abide by all office policies listed above.

Patient Signature_____ Date_____

Name (please print)_____

Witness Signature _____ Date_____

Name (please print)_____

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ . _____ 3. _____ . _____

2. _____ . _____ 4. _____ . _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)