

PRESCRIPTION ORTHOPEDIC AND SPORTS THERAPY PATIENT REGISTRATION FORM

Completed by: _____

Date: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Name: _____ Male Female

Street: _____ Apt. No.: _____ P.O. Box: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Sec #: _____ Date of Birth: ___ / ___ / _____

Referring Physician: _____ PCP Pediatrics Orthopedics Other

E-Mail: _____

*EMAIL WILL BE USED FOR OUR POST NEWSLETTER AND OTHER RELEVANT MEDICAL INFORMATION

RESPONSIBLE PARTY INFORMATION, IF MINOR (UNDER 18)

Last Name: _____ First Name: _____ Tel: _____

Street: _____ Apt. No.: _____ P.O. Box: _____ City: _____ State: _____

Zip Code: _____

Home Phone: _____ Work Phone: _____ Date of Birth: ___ / ___ / _____

PRIMARY INSURANCE COMPANY INFORMATION

Company Name: _____ Group Name or Number: _____ Effective Policy Date: _____

ID #: _____ Co-pay Amount: _____

Subscriber Last Name: _____ First Name: _____ Middle Initial: _____ Male Female Date of Birth: ___ / ___ / _____

Street: _____ Apt. No.: _____ P.O. Box: _____

Insured's Employer: _____ Check box if secondary insurance HIPPA info received

WORKMAN'S COMPENSATION OR MVA INSURANCE INFORMATION

Company Name: _____ Policy Number or Claim Number: _____ Date of Injury: _____

INS Address: _____ City/State: _____ Zip Code: _____

Adjuster: Last Name: _____ First Name: _____ Phone Number: _____

Lawyer: Last Name: _____ First Name: _____ Phone Number: _____

PRIMARY CARE PHYSICIAN

Primary Care Physician: _____ Tel: _____

Address: _____ City: _____ State: _____ Zip Code: _____

PATIENT MEDICAL HISTORY

Valve defects/prolapsed Cancer Previous Surgeries:
 History of heart attack Diabetes Type: _____ Date: _____
 High blood pressure Epilepsy/seizure disorder Type: _____ Date: _____
 Asthma Osteoporosis Previous Fractures:
 Bronchitis Arthritis Location: _____ Date: _____
 Musculoskeletal Problems: i.e. muscle strains, Casted Pinned Metal plate/Rod
Ligament strains Location: _____ Date: _____
 Other: _____ Casted Pinned Metal plate/Rod

If you answered yes to any other these conditions, please list medications: _____

**PRESCRIPTION ORTHOPEDIC AND SPORTS THERAPY
PRESENT INJURY/MEDICAL HISTORY**

1. What is your reason for coming to physical therapy?

2. What type of activities were you doing at the time of the injury?

3. How long have you had your present problem?

4. Did you receive treatment at the time of problem? If yes, please describe:

Did treatment help?

5. What activities/positions help your present problem?

What activities/positions aggravate your present problem?

6. On a scale of 0 – 10, (10 being most painful) how severe is your pain?

On a scale of 0 – 10, (10 being most normal) how much function do you have?

7. Have you had other injuries/conditions that you believe contribute to your present problem?

8. Please state your goals in physical therapy:

9. Have you received physical therapy for this condition at another facility? Yes No

If so, where?

10. Are you taking any medications for your present problem?

11. How did you hear about P.O.S.T.?

DOCTOR'S REFERRAL ___ PCP ___ ORTHOPEDIST ___ INSURANCE COMPANY ___ WEBSITE ___ YELLOW
PAGES ___ FRIEND/FAMILY MEMBER ___

*IF OTHER, PLEASE DESCRIBE:

PRESCRIPTION ORTHOPEDIC AND SPORTS THERAPY

Brookline Office

235 Cypress Street, Suite 100
Brookline, MA 02445
Tel: (781) 383-8767 Ext 9, 3
Fax: (617) 731-4162

Boston Office

(Inside FitCorp)
800 Boylston Street
Boston, MA 02199
Tel: (781) 383-8767 Ext 9, 2
Fax: (617) 421-0177

Cohasset Office

223 Chief Justice Hwy., #LL4
Cohasset, MA 02025
Tel: (781) 383-8767
Fax: (781) 383-8687

CONSENT TO DISCLOSE HEALTH INFORMATION FOR PAYMENT, TREATMENT AND HEALTH CARE OPERATIONS

Patient Name: _____
Home Address: _____
Home Phone: _____ Date of Birth: ___/___/_____

- Acknowledgement of notification of Practice Notice of Privacy Practices:

By my signature below, I acknowledge that I have read a copy of the Practice's Notice of Privacy Practices.

CONSENT TO DISCLOSE MY GENERAL HEALTH INFORMATION

By my signature below, I hereby authorize the Practice to disclose my medical information so that the Practice may treat me, seek payment from third party for such treatment and generally carry all the Practice's health care operations. I also authorize the Practice to disclose my medical information to insurer and providers outside of the Practice when necessary so that these providers may treat me, seek payment for that treatment, and for the purpose of their health care operations.

Patient Signature

Date

Please Initial below:

_____ ** I authorize the Practice to disclose my medical information on my home answering machine/voice mail.

_____ ** I authorize the Practice to disclose my medical information to my spouse, children and the following additional family and/or friends: _____

BILLING POLICY

We welcome you as a patient and appreciate the opportunity to provide you with quality physical therapy. We would like to inform you of our billing policy. We will submit bills to most insurance companies on your behalf. Some insurance companies pay fixed rates for physical therapy procedures and others pay a percentage of the charge. This information is verified for each patient by a member of our staff as a courtesy and is based on the assumption that you are entitled to physical therapy benefits. This verification is not a guarantee of benefit or payment. You should also follow up with your insurance company to find out your physical therapy eligibility and benefits. It is your responsibility to understand your insurance policy.

Please note that you may not be entitled to physical therapy benefits if:

- You have undergone previous physical therapy for a similar injury
- You belong to a healthcare group with no out-of-network benefits
- You have not obtained the proper managed care authorization

By signing below you authorize payment of all benefits to P.O.S.T., Inc. for services rendered to yourself or others for whose medical benefit you are responsible. If claims are not paid to P.O.S.T., Inc. within 60 days of billing, you will be billed directly, and payment is expected within 30 days.

Your signature below also authorizes the release of any and all medical records as requested by your physician, nurse, rehabilitation specialist, insurance company or attorney when appropriate. Regular reports are automatically provided to referring physician(s) as an update of your progress in physical therapy.

COPAYS

All copays, co-insurance payments and deductibles required by your insurance policy are the contractual obligation between you and your insurance company, and are expected at the time of the visit.

REFERRALS

If a primary care physician's referral or prescription is needed, it is the patient's responsibility to obtain the referral prior to the visit. If you do not have a referral at the time of the visit, you may be responsible for the payment in full.

CANCELLATIONS

We require 24-hour notification for cancellation of any appointment. Please be aware that there is a \$30 charge for your first missed appointment. There will be a \$60 charge for any subsequent missed appointments.

SIGNATURE: _____

DATE: _____

If you have any questions, please contact any member of our administration team. A copy of this policy and the verification of insurance benefits will be provided at your request.

PAYMENTS OF BENEFITS	MEDICAL RELEASE AUTHORIZATION
<p>I authorize payment of benefits as determined by the Insurance Company directly to:</p> <p>POST Physical Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>I understand that even if I have checked "Yes" above I may still be responsible for any amounts not paid by my Insurance Company in the event that the charges made are not reasonable and customary.</p> <p>_____ Signature of Patient or Legal Guardian Date</p>	<p>Insured party must sign for all claims. Dependent patient must sign if not minor. I authorize any insurance company, organization, employer, hospital physician, dentist, or pharmacist to release any information requested with regard to processing my claim. I certify that the information I furnish is true and correct. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.</p> <p>_____ Signature of Patient or Legal Guardian Date</p>

FOR OFFICE USE ONLY	
Copy of Insurance Card? <input type="checkbox"/> Yes <input type="checkbox"/> No	Eligibility Checked? <input type="checkbox"/> Yes <input type="checkbox"/> No