

# P.O.S.T.

## 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 \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Referred By \_\_\_\_\_

### RESPONSIBLE PARTY INFORMATION, IF MINOR (UNDER 18)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_  Male  
 Female

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 Name: Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  Male  Female Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Street \_\_\_\_\_ Apt. No. \_\_\_\_\_ P.O. Box \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Insured's Employer \_\_\_\_\_  Check box if secondary insurance  HIPPA info received

### PRIMARY CARE PHYSICIAN

Primary Care Physician \_\_\_\_\_ Tel: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

### REFERRING PHYSICIAN

Referring Physician \_\_\_\_\_ Tel: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

### PATIENT MEDICAL HISTORY

Value defects/prolapse  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, ligament strains Casted Pinned Metal Plate/Rod  
 Other \_\_\_\_\_ Location \_\_\_\_\_ Date \_\_\_\_\_  
Casted Pinned Metal Plate/Rod

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

\_\_\_\_\_  
\_\_\_\_\_

**P.O.S.T.**  
**PATIENT REGISTRATION FORM**

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

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

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3. How long have you had your present problem?

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

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Did treatment help?

5. What activities/positions help your present problem?

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What activities/positions aggravate your present problem?

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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?

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8. Please state your goals in physical therapy:

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

Where?

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

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How did you hear about P.O.S.T.? Doctor's referral \_\_\_\_\_ Yellow page \_\_\_\_\_ Family/Friend \_\_\_\_\_

Insurance company reference \_\_\_\_\_ PTPN \_\_\_\_\_ Other (please describe) \_\_\_\_\_

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# PRESCRIPTION ORTHOPEDIC SPORTS THERAPY

**Brookline Office**  
235 Cypress Street, Suite 100  
Brookline, MA 02445  
Tel: (617) 738-1004  
Fax: (617) 731-4162

**Boston Office**  
800 Boylston Street  
Boston, MA 02199  
Tel: (617) 421-4477  
Fax: (617) 421-0177

**Cohasset Office**  
223 Chief Justice Cushing 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 \_\_\_\_\_

### — Acknowledgment 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 parties for such treatment and generally carry all the Practice's health care operations. I also authorize the Practice to disclose my medical information to insurers and provider 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.

\*\*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 friends \_\_\_\_\_.

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date

## 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 benefit. 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
- this injury is related to a motor vehicle accident
- you belong to a healthcare group with no out-of-network benefit
- 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. **All 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.**

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.

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.**

As a courtesy to all of our patients, we require 24-hour notification for cancellation of any appointment. **Please be aware that there is a \$25 charge for any 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 benefit will be provided at your request.

PAYMENTS OF BENEFITS		MEDICAL RELEASE AUTHORIZATION	
I authorize payment of benefits as determined by the Insurance Company directly to: Surgeon/Physician <input type="checkbox"/> Yes <input type="checkbox"/> No 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.		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.	
_____ Signature of Patient or Legal Guardian	_____ Date	_____ Signature of Patient or Legal Guardian	_____ Date
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	