Back On Track
Physical Therapy
**Phone: 617-730-5337 Fax: 617-730-5461**

**Patient Name**_____

## New Patient Information

**Patient Name**_____**Date of Birth**___/___/_____**SS#**_____
Address_____ City_____Zip_____
Best phone# to reach you_____ Secondary#_____
Email address_____
Gender M_____ F_____
If you are a minor, please print guardian's name_____

**Health Insurance Co.**_____
Policy ID#_____Group ID#_____
Primary Card Holder (if not self)_____DOB (if not self)_____
Your relationship to primary card holder (if not self)_____

**Referring Physician**_____**Phone**_____
**Primary Care Physician**_____**Phone**_____

**Have you had physical therapy at any other facilities this year? NO YES If yes, how many visits?____**
**Have you treated for this condition before? NO YES If yes, when?_____**

**Medical History – please check any that apply and indicate past or present.**

| | |
|---|---|
| High Blood Pressure | Surgery |
| Heart Attack | Trauma |
| Angina/Chest Pain/Palpitations | Fractures |
| Heart Disease | History of Abuse |
| Stroke | Arthritis |
| Diabetes | Osteoporosis |
| Cancer or Tumors | Orthopedic Injuries (specify) |
| Respiratory or Lung Conditions | Kidney or Liver Disease |
| Shortness of Breath | Smoking |
| Asthma | Drug or Alcohol Dependence |
| Allergies | Anxiety |
| Tuberculosis | Depression |
| Hepatitis | Pain at Night |
| HIV/Aids | Incontinence |
| Seizures/Epilepsy | Recent weight loss/gain |
| Chronic Headaches/Migraines | Coordination Problems/Balance/Falls |
| Phlebitis/Thrombosis | Head Injury |
| Skin Diseases (specify) | Hospitalizations |
| Contagious Disease (specify) | List medications: |
| Pregnancy Cesarean Y N | |

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## Patient Intake Questionnaire

**Please describe your current complaint and functional limitations**

_____

_____

When did your problem begin?_____
How did your problem begin? _____
Have you had recent surgery? NO YES If yes, when?_____
Please describe the nature of your pain

Sharp pain___
Dull Pain/Ache___
Throbbing___
Numbness___
Shooting ___
Burning___
Tingling___

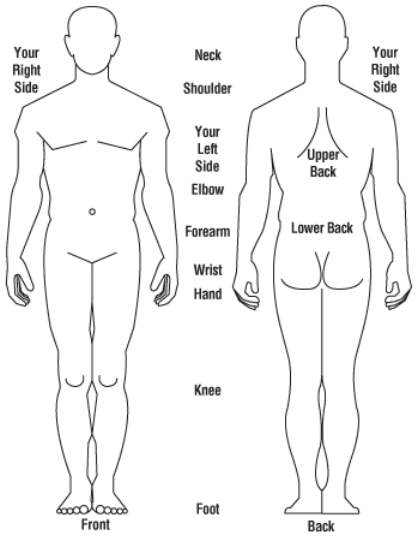
Constant (76-100%) ___
Frequent (51-75%)___
Occasional (26-50%)___
Intermittent (25% or less)___
Other_____

Indicate the intensity of your pain at rest:
No pain 1 2 3 4 5 6 7 8 9 10 Unbearable pain

Indicate the intensity with movement:
No pain 1 2 3 4 5 6 7 8 9 10 Unbearable pain

Have your symptoms been Increasing___, Decreasing___ or Not Changing____
When are your symptoms worse? Morning___ Afternoon___Night___ As the Day Goes On___ Same All Day____
What makes your problem better?_____
What makes your problem worse?_____
Have you ever been treated for this problem before? NO YES
Are you now being treated, or have you seen anyone for this condition? NO YES If yes, Who?_____
What has helped?_____
Your occupation_____ Has your work status changed because of this condition? NO YES

Please use the Symptom Key to indicate the areas where you have pain or other symptoms:




Are there any activities that you normally perform that are limited due to this condition? NO YES
If yes, please describe_____
_____

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Aside from your prescribed condition, do you have any other symptoms that you would like to discuss? NO YES
If yes, what?_____
Would you like assistance with weight loss or building a daily exercise routine? NO YES

Some additional services may be covered by your insurance company. Others may require out-of-pocket costs that are not covered by your insurance. Feel free to discuss this with your therapist or with our administrative staff. We offer full-service physical therapy and wellness to better your future.

**Patient Signature**_____ **Date**_____

**Back On Track Physical Therapy, P.C.**
**Notice of Privacy Rights and Practices Patient Acknowledgement**

We are required by the federal law known as "the Health Insurance Portability and Accountability Act" (HIPAA) as well as by Massachusetts' law to maintain the privacy of your medical and health information, also referred to as "Protected Health Information" (PHI).

Our Notice of Privacy Rights and Practices describes how information about your may be used and disclosed and how you can obtain access to this information. Please review it carefully. When we use or disclose your Protected Health Information, we are required to abide by the terms of the Notice (or any other notice in effect at the time of the use or disclosure).

You have the right to request in writing that we restrict how Protected Health Information about you is used or disclosed. We are not required to agree to this restriction, but if we do, you will receive written confirmation of our agreement to which we will be bound.

Your signature below constitutes your acknowledgment that you have been offered the opportunity to read a copy of our Notice of Privacy Rights and Practices, and your consent under Massachusetts' law to the kinds of uses and disclosures of Protected Health Information mentioned in our notice.

Patient's Signature_____ Date_____
Or
Personal Representitive_____Relationship to Patient_____

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**Patient Name**_____

# Billing Policy

Back On Track will check insurance eligibility and benefits prior to your evaluation.
This includes:
- Your physical therapy benefit for the calendar year or your plan year
- The need for referrals, pre-authorization or continued authorization for the duration of your treatment
- Patient financial responsibility - including copays, deductibles, coinsurances & optional supplies

**IF YOUR PLAN REQUIRES A REFERRAL, you should call your PCP's office and request one.

**Our National Provider ID (NPI) is 1376593368 and our fax number is (617) 730-5461.**

***Though we check this information, we recommend that YOU also verify it by calling the member services number on your insurance card. The information given to us is subject to human error and Back On Track will not be held responsible if we are given misinformation. This does not verify coverage or guarantee payment. All unpaid services are the patient's responsibility.

**Initial**_____

**Patient Financial Responsibility**
If you have a deductible or a coinsurance attached to your plan (this includes Medicare patients) and no secondary payer, your balance will be assessed once your charges are processed and we receive an explanation of benefits. These benefits may change if your plan changes. Any balances owed are patient responsibility.
- Copays are due AT THE TIME OF SERVICE. Back on Track does not invoice copays.
- Supplies and exercise equipment are not subject to billing. Payment is due upon delivery of supplies or equipment.

**Initial**_____

***Any monies collected at the office, via mail or phone payments will be applied to your oldest balance due - which may include copays, deductibles, coinsurances, cancel/no-show fees.

**Initial**_____

**Cancellations and No-Shows**
Your time, as well as the time of our therapists, is important to us. In order to support prescribed treatment plans for our patients, Back On Track requires at least one-day's notice for cancellations so that we may call patients who may have had difficulty booking in advance. We understand that unforeseen circumstances may arise, and therefore, we allow 3 same-day cancellations or no-shows at no charge before we implement a $25 fee for each 30 minutes of treatment missed. Patients with Mass Health plans will be subject to same-day scheduling only if late cancels and no-shows are chronic.

**Initial**_____

**Consent to Treat**
I voluntarily authorize Back On Track Physical Therapy to perform outpatient diagnostic evaluation(s) and/or procedure(s) and to administer such outpatient therapy as is necessary. I understand that outpatient therapy is not an exact science and no guarantee has been made as to the result and any treatment of care administered.

**Initial**_____

**Authorization to Release Information**
I authorize Back On Track Physical Therapy to release information relative to any therapy administered to any third party payer(s) financially responsible for these services or to my referring or primary physician or therapist.

**Initial**_____

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**Worker's Compensation and Motor Vehicle Accidents Only**

**Please describe how the accident occurred:**

_____

_____

_____

Did you lose consciousness? NO YES If yes, how long?_____
Were you wearing a seatbelt? NO YES N/A
Were you transported by ambulance? NO YES
Have you ever been in an auto accident before? NO YES N/A If yes, what year?_____

**Worker's Compensation Insurance Information**

Insurance Company Name_____
Address_____
City, State, Zip_____
Adjuster's Name_____Phone_____Ext_____
Claim#_____ Policy#_____

Have you treated for this condition before? NO YES

If you have not filed a W/C claim, but you were injured performing your job, you must contact your employer for the necessary paperwork and open a claim. Otherwise, your treatment will not be covered.
Have you informed your employer and opened a claim for this injury? NO YES

**Automobile Insurance Information**

YOUR Auto Insurance Company Name_____
Address_____
City, State, Zip_____
State where you are insured_____
Adjuster's Name_____ Phone_____Ext_____
Claim#_____ Policy#_____

If you have been in an automobile accident and wish to be covered by your auto insurance company for medical treatment, you must fill out a PIP application with your insurance company.
Have you completed and returned your PIP application to your auto insurance company? NO YES

Have you treated for this condition before? NO YES

**ARE YOU BEING ADVISED BY AN ATTORNEY? NO YES**

If yes, Name of Attorney_____Phone_____

Signature to release information to above mentioned attorney_____