Back On Track
Physical Therapy

New Patient Information
PLEASE FILL THIS FORM OUT COMPLETELY

Patient Name: ______________________________ **Date of Birth:** ____/____/_______ **SS#:** ____________________

Address: ____________________________________ **City:** ______________________ **Zip**: ____________

Home phone #: (____) _______________ **Cell/ Work phone #:** (____) ______________ **Sex: M** ☐ **F** ☐

E-mail Address:____

Date of Injury: _________________________ **Part(s) of Body Injured:** _____________________________________

If you are a minor, Guardian Name: ______________________________ Relationship to you: ___________________

Are you allergic to any medications? NO YES If yes, please list: ____

Health Insurance Co.: ________________________________ Telephone: ____________________________________

Policy ID#: _______________________________________ Group #: _________________________________

Primary Card Holder: ________________________________ Primary Card Holder DOB: ________________________

Primary Card Holder's Employer: ______________________ Your relationship to Primary Card Holder: ____________

Referring Physician:____ Phone #:____________________________

Primary Care Physician_____ ___________________________________ Phone #:____________________________

Have you treated 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? _________________________

Are you being advised by an Attorney? NO YES

Name of Attorney: ____

Name of Law Firm: ____

Address: ____

City, State, Zip: ____

Telephone: __________________________________ Fax: _______________________________________

Automobile Insurance Information

(complete this section if you were injured in a motor vehicle accident)

Vehicle #1 (Vehicle YOU were in at time of accident)

Insured's Name: _____________________________

Address: __________________________________

City, State, Zip: _____________________________

Auto Insurance Co.: _______________________________

Address: __________________________________

City, State, Zip: ____________________________

Telephone: ________________________________

Claim #: ___________________________________

Name of Adjuster: ___________________________

Policy #: __________________________________

Vehicle #2 (other Vehicle involved)

Insured's Name: ________________________

Auto Insurance Co.: ___________________________

Address: ______________________________

City, State, Zip: _________________________

Telephone: _____________________________

Claim #: _______________________________

Name of Adjuster: _______________________

Policy #: ______________________________

IN THIS ACCIDENT, WERE YOU THE: DRIVER PASSENGER PEDESTRIAN

Please describe how the accident occurred:

____

____

____

Did you lose consciousness: NO YES If yes, how long: ____________________________________

Were you wearing a seat belt: NO YES

Was your vehicle ***stopped*** or ***moving*** at the time of the accident? ____________________________________

Were you transported by ambulance? NO YES Were X-rays taken? NO YES

Have you ever been in an auto accident before? NO YES If yes, what year? ____________

Worker's Compensation Insurance Information *(complete this section ONLY if you were injured at or during work)*

Insurance Co. Name: ____

Address: ____

City, State, Zip: ____

Claim #: ______________________________ Policy #: _____________________

Adjuster's Name: _________________________ Ext: ________________________

Does your employer know you were injured at work? NO YES

Did your employer file a First Report of Injury? NO YES If yes, when? ______________________

Have you ever been injured at work before? NO YES

BILLING POLICY

We would rather spend more time dealing with you and your medical issues than with your insurance company. In order to better serve you, we ask for your assistance to help simplify several issues with regard to your insurance claim.

- We recommend that you check with your insurance company regarding eligibility status, deductible and co-payment. Please do so prior to your visit in order to minimize any unpleasant surprises with regard to your coverage. We will also verify your benefits prior to your initial appointment.

- HMO members – if your HMO requires a referral from your primary care physician (PCP), **your referral must be received by our office on or before the day of your first appointment.**

- This insurance benefit information does **not** verify coverage nor does it guarantee payment. Unpaid services are the patient's responsibility. Copays are due *at the time of service* and deductible amounts are the responsibility of the patient and will be invoiced after the insurance carrier processes the patient claim.

- **MEDICARE PATIENTS**: Medicare **will not** cover outpatient physical therapy if a patient is currently receiving home health services or begins to receive these services during their period of active treatment. If you have received **any type** of home health care services in the past 6 months, ***you must provide us a document stating that you have been fully discharged from the agency that provided these services to you prior to starting treatment at Back On Track. *** See Attached Form******

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 you may be used and disclosed and how you can obtain access to this information. Please review if 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 Representative: ______________________________________ Relationship to patient: ________________

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 that is necessary. I understand that outpatient therapy is not an exact science and no guarantee has been made as to the result of any treatment or care administered. **Initial:** ______

Cancellation Policy

Your time as well as the time and effort of our therapists is important to us. Your appointment time is specifically reserved for you; therefore, missed appointments or cancellations without 24-hour notification will result in a fee which is based upon the therapist and the duration of your visit. ***Fees range from $25 to $80.*** **Initial:** ______

Authorization To Release Information

I authorize Back On Track Physical Therapy to release information relative to any therapy administered to any third-party payor(s) financially responsible for these services or to my referring /or primary physician or therapist.
Initial:______

Acknowledgment of Terms

By signing below I attest that all information given is true and accurate to the best of my ability. I understand that intentionally providing misleading information is unlawful. I have read and understand the policies stated above. I acknowledge that I am ultimately responsible for charges incurred as a patient of Back On Track Physical Therapy.

I certify, under the pains and penalties of perjury, that the information contained in these forms is true and accurate to the best of my knowledge and will promptly notify you of any changes of inaccuracies.

PATIENT SIGNATURE: ______________________________ **DATE:** ________________

What prompted you to come to our facility? (Please circle one or more of the following)

- Referring Physician
- Previous Experience
- Recommended by ______________________________
- Convenient Hours
- Near Public Transportation
- Phone Book
- Convenient Location
- Other: ____________________

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