Tewksbury Physical Therapy, 885 Main Street, Unit 4, Tewksbury, MA 01876

Name: _____ Date of Birth: _____ Age_____

Address: _____ Home Phone ( ) _____-_____
(Number & street)

_____ Cell Phone: ( ) _____-_____
(City or town) (State) (Zip code)

Occupation: _____ Work Phone: ( ) _____-_____

Employer: _____

Address: _____ Email: _____

Can a member of our staff leave a message on: **Home phone** (Y) or (N) **Cell phone**(Y) or (N) **Email**(Y) or (N) if needed?

In case of emergency, who should we contact?

_____Relationship_____Phone_ (_____) _____

Insurance Information:

Primary Insurance Company: _____ID#:_____

Subscriber: _____ Subscriber D.O.B._____ Relationship to subscriber: _____

Secondary Insurance Company: Please list any secondary insurance here. This would include Medicare supplement plans and your private insurance if a worker's compensation or auto carrier is primary.

Secondary Insurance Company: _____ ID#_____

Subscriber: _____ Subscriber D.O.B._____ Relationship to subscriber: _____

Have you been treated for PT anywhere in the last 12 months? ☐ Yes ☐ No Where: _____

If **Medicare**, are you receiving or have you recently received **ANY** home services (including a nurse, home health aide)
Yes____ No_____ Date of discharge: _____

Check if worker comp or auto accident: W/C claim? _____ Auto accident? _____ Date of Injury: _____

INSURANCE & PAYMENT POLICY

Patient payments vary with insurance plans. Most plans have either a deductible, copay or co-insurance amount for each visit. Some insurance plans require pre-authorization or insurance referral. Please check with your insurance company if you are unsure. Should your insurance company deny payments, you will be responsible for payment of charges.

I authorize release of my medical records to my insurance company if necessary, to process my claim. I understand I am responsible for any payment of charges that is not paid by insurance. I understand that I am responsible for obtaining an insurance referral if needed by my insurance company. If anything is to change with my insurance I understand I have to notify the billing staff when changes occur.

Patient/Guardian Signature: _____ Date: _____

*PLEASE FILL OUT THE BACKSIDE OF THIS FORM & SIGN

TREATMENT CONSENT, PATIENT PRIVACY & MEDICAL INFORMATION POLICIES

Physical Therapy (PT) is patient care services provided in response to a wide range of medical care needs of our patient of all ages regardless of gender, color, race, creed, national origin or disability. The purpose of P.T. is to treat disease, injury and disability by elevation, examination, testing and use of rehabilitation procedures, manipulations, massage, exercises, and physical agents including, but not limited to mechanical devices, heat, cold, light, water, electricity and sound in the aid of establishing a physical therapy functional diagnosis and treatment program; to obtain the information needed in evaluation of patients to prevent or minimize residual physical disability. P.T. can aid the patient in achieving their maximum potential within their capabilities, and accelerate convalescence and reduce the length of functional recovery. P.T. practice includes, but is not limited to, patient education, electrical stimulation, phonophoresis, iontophoresis, and application of topical medications, splinting and biofeed services. You are not expected to experience any increase in your current pain level or discomfort. You should attempt to stop each procedure before you experience any increase in your current level of pain and discomfort and discuss this with your therapist. You may be asked to partially disrobe, in which case a hospital gown will be provided. If this is necessary, your privacy and dignity will be considered at all times by the staff. Should you feel uncomfortable, you may refuse, stop the procedure and/or request another therapist. There are certain inherent risks with PT treatment because you will be asked to exert effort and perform activities with increasing degrees or difficulty which could cause an increase in your current level of pain and discomfort. There is a possibility that you could experience a new injury, but this risk is small and you can control this by stopping if you feel any increase symptoms, or sense of new symptoms developing. Your physical therapist will take every precaution to ensure that you are protected from any potentially hazardous situation. You will never be forced to perform any procedure and/or comply with a treatment that you do not wish to perform and/or have performed on you.

Based on the above information, I agree to cooperate fully and to participate in all PT procedures. I give my consent to be evaluated and treated in PT. I acknowledge that I have read and received a copy of the Authorization for treatment letter. I authorize release of medical information to appropriate third parties. I have seen the notice of information of practice regarding patient privacy laws and provisions posted by the front desk.

Patient/Guardian Signature: _____ Date: _____/_____/_____

Witness: _____ Title: _____ Date: _____/_____/_____

CANCELLATION & NO-SHOW APPOINTMENT POLICY

Therapy Attendance Policy: Our office requires a 24-hour notice for appointment cancellations. At Tewksbury Physical Therapy, we want you to get the most out of your PT visits. Attending all your scheduled treatment sessions can significantly increase your success. We encourage you to develop a workable schedule with your therapist.

A $75 missed fee will be charged on your second No-Show and cancellation given within less than 24-hour notice.
This amount is your responsibility; insurance companies will not cover a missed fee visit.

Your 1st No-Show or late cancellation: You will receive a phone call informing you that you had missed the scheduled appointment. As a courtesy, we will waive the fee for the first occurrence.

Repeated No-Show/late cancellations: You will be required to call-in for same day scheduling or possible discharge. You must call for an open appointment on the day you would like to receive therapy (appointments based on availability.)

I UNDERSTAND AND HEARBY AGREE TO ADHERE TO THE THERAPY ATTENDANCE POLICY.

Patient/Guardian Signature: _____ Date: _____/_____/_____

CLINICAL INFORMATION

Patient Name: _____

Gender: ☐ Male ☐ Female ☐ Non-Binary Height: _____ Feet _____Inches Weight: _____

Treatment Area: _____

Date Symptoms Started: _____ Surgical Date: _____ Next Doctors appointment: _____

Referring Doctor: _____ Primary Care Doctor_____

Allergies: _____

_____ Injections: ☐ Yes ☐ No When: _____

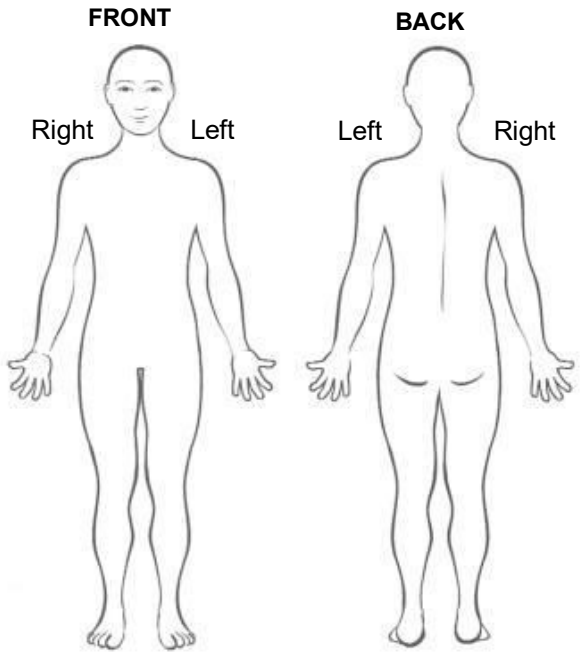
Your Pain Level in the PAST WEEK: (CIRCLE ONE)

	No Pain										Worst Pain
Lowest:	0	1	2	3	4	5	6	7	8	9	10
Average:	0	1	2	3	4	5	6	7	8	9	10
Highest:	0	1	2	3	4	5	6	7	8	9	10

Describe Your Pain:

- ☐ Burning
- ☐ Sharp
- ☐ Achy
- ☐ Throbbing
- ☐ Numbness/Tingling
- ☐ Other: _____

Please Place an "X" on the Area of Pain



How often do you experience your symptoms %of the time

1 Constantly (76-100%) 2 Frequently (51-75)

3 Occasionally (26-50) 4 Intermittently (0-25%)

*PLEASE FILL OUT THE BACKSIDE OF THIS FORM & SIGN

PAST MEDICAL HISTORY

- ☐ No Known Significant Past Medical History
- ☐ Alzheimer's or Dementia
- ☐ Cerebral Vascular Accident(Stroke)
- ☐ Diabetes Mellitus Type 1/ Type 2
- ☐ Fibromyalgia
- ☐ Immune Disorders or Immunosuppression
- ☐ High Blood Pressure
- ☐ History of Cancer
- ☐ Parkinson's Disease
- ☐ Traumatic Brain Injury/Concussion
- ☐ Osteoarthritis
- ☐ Osteopenia/Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ High Cholesterol
- ☐ Neurologic Disorders
- ☐ Back or Neck Pain
- ☐ Heart Attack (Myocardial Infarction)
- ☐ Congestive Heart Failure/ Heart disease
- ☐ Pulmonary Conditions (COPD/Emphysema)
- ☐ Kidney/Bladder Problems
- ☐ Gastrointestinal Issues
- ☐ Pacemaker / Prosthesis / Implants
- ☐ Visual Impairments
- ☐ Sleep Dysfunction
- ☐ Headaches/ Migraines
- ☐ Asthma
- ☐ Allergies
- ☐ Depression
- ☐ Anxiety or Panic Disorders

Other Medical History/ Surgeries: _____

_____

CURRENT MEDICATIONS

Prescription, Over-the-Counter Medications, & Supplements	Frequency	Dosage
☐ **SEE ATTACHED LIST WITH ALL CURRENT MEDICATIONS, FREQUENCY, AND DOSEAGES**		

SIGNATURE REQUIRED- *I attest that all the information provided is current and accurate as of today's date.*

Print Name (Full): _____

Patient Signature: _____ Date: _____

Guardian Signature: _____ Relationship to Patient: _____