NEWTON PHYSICAL THERAPY

New Patient Information Form

Patient Name: _____ Initial Visit: ____/_____/_____

D.O.B: ____/____/_____ Cell: _____ Home Phone: _____

Email: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Are you using insurance for physical therapy? Yes: _____ No: _____ (If no skip to Referral)

Primary Insurance	Secondary Insurance
Company Name:	Company Name:
Subscriber ID #:	Subscriber ID #:
Group #:	Group #:

Deductible: _____ Copay: _____ Coinsurance: _____

Name of Insured (if different than above): _____

Insured's D.O.B (if different than above): ____/____/_____ Insurance effective date: ____/____/_____

Is your condition related to a recent injury or incident? Yes: _____ No: _____

Date of injury/incident: ____/____/_____ Please explain the injury/incident or why you are seeking care: _____

_____

Have you had surgery for this condition? Yes: _____ No: _____Date of Surgery ____/____/_____

Have you been treated for a similar condition, now or in the past? Yes: _____ No: _____ If so, by who, and what was your diagnosis, and any details: _____

_____

Referral: Have you obtained a doctor's referral for physical therapy? Yes: _____ No: _____

If no, please explain: _____

Signature of Patient (or Guardian):_____ ***Date:*** **____/____/_____**

If Guardian, state relationship to the patient: _____

Doctors: PCP Name: _____ PCP City/State: _____

PCP Phone: _____ PCP Fax: _____

Referring Doctor Name: _____Referring Dr City/State: _____

Referring Dr Phone: _____ Referring Dr Fax: _____

ADMIN only: (initials) _____ QC that page 1 is complete and patient demographics entered

Past Medical History Questionnaire

Patient Name: _____

Have you ever received therapy before? *YES* *NO*

If so, when? _____

Could you be or are you pregnant? *YES* *NO*

Do you now or have you ever had any of the following:

	YES	NO		YES	NO
Arthritis	_____	_____	*Metal Implants*	_____	_____
Osteoporosis	_____	_____	*Cancer/Tumor*	_____	_____
High Blood Pressure	_____	_____	*Recent Weight Loss/Gain*	_____	_____
Heart Disease	_____	_____	*Current Infection(s)*	_____	_____
Heart Attack	_____	_____	*Tuberculosis*	_____	_____
Pacemaker	_____	_____	*Hepatitis*	_____	_____
Vascular Disease	_____	_____	*Thyroid Problems*	_____	_____
Stroke	_____	_____	*Headaches*	_____	_____
Asthma	_____	_____	*Head Injury/Concussion*	_____	_____
Shortness of Breath	_____	_____	*Hernia*	_____	_____
Chronic Cough	_____	_____	*Kidney/Bladder Problems*	_____	_____
Fainting Spells	_____	_____	*Previous Fractures*	_____	_____
Diabetes	_____	_____	*Previous Surgeries*	_____	_____
Anemia	_____	_____	*Hearing Loss*	_____	_____
Hypersensitivity to			*Depression*	_____	_____
Heat or Cold	_____	_____	*Anxiety*	_____	_____
Swelling in Ankles	_____	_____	*Substance Abuse*	_____	_____
Seizures/Epilepsy	_____	_____	*Allergies*	_____	_____
Deep Vein Thrombosis	_____	_____	*Other*	_____	_____

If you answered "yes" to any of the above, please explain and give approximate date(s):

_____

_____

_____

Are you presently taking any medications? If "yes," list all medications.

_____

_____

The information above is correct to the best of my knowledge.

_____ _____

Patient or Parent/Guardian Signature *Date*

NEWTON PHYSICAL THERAPY
383 ELLIOT ST, SUITE 250, NEWTON, MA 02464
Tel.617-916-1655 Fax.617-332-7601

FINANCIAL POLICY AND AGREEMENT

I, the undersigned, in consideration of the Office's services, agree to the following terms:

Definitions. In this Agreement, "Office" and "Clinic" shall refer to Newton Physical Therapy, located at 383 Elliot Street, Door F, Suite 250, Upper Newton Falls, MA, 02464. "Financial Policy" or "Agreement" shall refer to this document.

Authorization to Sign My Name on Payments; Transfer of Credit Balances. I authorize the Office to endorse or sign my name on any and all payments listing me as a payee which are received by the Office for payment of Charges incurred by me, my spouse or my dependents. In such cases, my printed name, followed by the phrase, "(by [Name of Office])," shall serve as a properly authorized endorsement. I further authorize the Office to apply any credit balances on my Charges to any other outstanding Charges still owed by me, my spouse, or my dependents, regardless of whether these other Charges are related to my condition.

Personal Responsibility for My Charges. I understand that I remain personally responsible for my Charges and that at any time, I can request a copy of my total Charges from the Office. Except where provided otherwise by law or by contract, I agree to pay the full amount of my Charges to the Office promptly upon its demand. I understand that the Office's Assignment does not constitute an agreement by the Office to await payment of my Charges. I agree that any delay by the Office in making demand for payment, any delay in paying the full amount of my Charges, and any partial payments received by the Office towards my Charges, shall not constitute acceptance of any installment payment plan, shall not constitute a waiver of the Office's right to receive payment-in-full promptly upon demand, and shall not constitute an "accord and satisfaction" of my Charges, regardless of any such terms or restrictions indicated on, or included with, any payments. I also agree that my account with your Office shall be construed as in "default" on the earlier of the following dates: (a) a Payer fails to pay any or all of the Charges in-full and directly to the Office upon receipt of those Charges within thirty (30) days or the period established by the earliest prompt pay deadline applicable to the Payer (whichever occurs later), (b) I do not pay any or all of the Charges in-full within fourteen (14) days of request, or (c) the Office attempts to charge my credit card in compliance with a written Payment Arrangement, but the charge is declined or not approved.

Personal Responsibility for Verifying the Limitations in My Coverage; Financial Responsibility for Non-Covered Charges. I understand that in any given situation, a Payer may initially refuse to make payment to the Office, may delay payment for an indefinite or unreasonable amount of time, or may actually request a refund from the Office after making payment, and do so either in whole or in part with respect to any given Charge incurred at the Office (collectively, "Deny Payment"). For example (without limiting this Agreement), I understand that a Payer may Deny Payment, stating that the Charge is "not a covered benefit" under its policy or exceeds some other limitation. I further understand that a Payer may Deny Payment stating that the individual provider who actually renders the treatment or procedure is out-of-network. I also understand that a Payer may claim, based on internal criteria, that a particular Charge is or was not medically necessary or was not sufficiently documented, and should therefore be denied or downcoded. I also understand that a Payer may require certain Charges to be pre-certified or pre-authorized. In the event that my condition arose from an accident, I further agree to the terms of the Office's Auto / Work Comp Advance Beneficiary Notices as applicable. I understand that there may be many other situations where a Payer may Deny Payment based on a particular contractual term applicable to me or to the Office (collectively, "Terms of Non-Coverage"). To the extent permitted by law or by contract, I agree that I am solely and exclusively responsible for verifying all Terms of Non-Coverage prior to incurring any Charges at the office. I agree that if I have any questions about the Terms of Non-Coverage, I can request copies of the Office's verification (e.g., eligibility, pre-authorization) forms to gain further understanding. I agree that should the Office assist me in any way in the verification, pre-authorization, or billing process, I assume the risk that the Payer and/or the Office may in my opinion not accurately understand and/or communicate the Terms of Non-Coverage and/or bill my Charges to my Payers. Should any Payer Deny Payment, or should any Payer be likely to Deny Payment as determined by the Office in its sole discretion, I agree that I am personally, fully, and immediately responsible for the portion of my Charges denied or likely to be denied. In no event shall I hold the Office responsible or liable in any of the foregoing instances.

Direction to the Office to Apply the Lowest Mandatory Fee Reduction When Two or More Payers Are Involved. Unless otherwise agreed to in writing, I authorize the Office to submit my Charges, as well as a copy of the Assignment & Lien, to any and all Payers, not including in accident cases my health benefit plan or Medicare. Notwithstanding the foregoing, in the event that the Office determines in its sole discretion that it has any reasonable basis for either submitting or not submitting my Charges and/or other documentation to a Payer, I hereby authorize the Office to take such action without condition or restriction. I understand that some or all of these Payers may utilize fee schedules which (a) the Office has agreed to accept, directly with said Payers in writing, or (b) law expressly imposes on the Office to accept (collectively, "Mandatory Fee Reductions"). I further understand that the Mandatory Fee Reductions imposed on the Office with respect to one Payer may exceed the Mandatory Fee Reductions imposed on the Office with respect to another Payer. In such an event, I hereby authorize and direct the Office insofar as permitted by law to apply the lower of the two Mandatory Fee Reductions to its Charges. I further agree that in the special event that Mandatory Fee Reductions are imposed on the Office by virtue of laws which regulate or restrict "balance billing," I hereby waive the application of such laws to the extent permitted by law. In the event that no Mandatory Fee Reductions are actually imposed on the Office with respect to a Payer, I authorize and direct the Office to collect up to its full Charges from such Payer.

Miscellaneous Provisions. Except as provided in this paragraph, this Agreement shall not be modified or revoked without the expressed, written consent of the Office. I hereby revoke, with the Office's consent, the terms of any previously signed documents, but only to the extent those terms conflict with the terms of this Agreement. I agree that each and every provision of this Agreement is reasonably necessary. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of

this Agreement shall, nevertheless, remain in full force and effect. This Agreement shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. In any action based upon this Agreement, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum inconvenience. I further waive any statute of limitations which may apply in any action based upon this Agreement. I have reviewed the Office's "Assignment & Lien", Health Insurance Election, and, if applicable, Auto / Work Comp Advance Beneficiary Notices, and further agree to the terms and definitions set forth in these documents as applicable. Said documents are incorporated herein by reference. In the event that my condition is related to an accident, including without limit automobile accident, I understand that there will be an administrative fee necessary to cover the costs of verifying multiple Payers, filing and terminating liens, and submitting notices of same to Payers.

I have read, understood, and agree to the terms of this Agreement.

Patient Name (print): _____ Patient Signature: _____

Date: _____/_____/_____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (please print): _____

Parent/Guardian Signature: _____ Date: _____/_____/_____

NEWTON PHYSICAL THERAPY

PLEASE READ CAREFULLY BEFORE SIGNING – THANK YOU

CANCELLATION POLICY – Please notify us as soon as possible if you are unable to keep your appointment. Our answering machine is on 24-hours a day.

Please help us to serve all members by providing us as much notice as possible.

Our goal is to never to have to charge our patients for cancellations, so here is a friendly reminder to help avoid any charges in the future for cancellations made outside of our policy / agreement.

- **Physical Therapy** appointments - a **24 hour notice** is required to cancel or you will be charged a **$35 fee.**

- Please notify us as soon as possible if you are unable to keep your appointment, including after business hours as our answering machine is on 24 hours a day.

Please note *- emergencies will be taken into consideration.*

It is our commitment to serve as many people as we can, providing the highest quality care at an affordable rate.

In order to keep this commitment to the members of our practice, strict enforcement of the cancellation policy is necessary.

I have read, understand, and agree to the above policies.

_____ _____

Patient (or guardian) Signature ***Date***

NEWTON PHYSICAL THERAPY

PATIENT CONSENT FORM

Regarding the Use & Disclosure of Protected Health Information

("Consent Form")

For the purposes of this Consent Form, "Office" shall refer to: Newton Physical Therapy.

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

Patient Name (please print): _____

Signature: _____ Date: ___/___/_____