HOUGHTON

PHYSICAL THERAPY &
SPORTS CONDITIONING

80 Park Street, Attleboro, Ma 02703 508-223-2300

NEW PATIENT CHECKLIST

If you need to see a physical therapist, you want to get the most out of each and every visit. Before you can show up for a visit, you want to make sure that you are well prepared. By calling your insurance company, finding the right practitioner and arriving early, you will be ready to begin at the very first appointment you make.

❖ Call Your Insurance Company

The customer service phone number should be on the back of your card. Ask about your physical therapy out-patient benefits. It may also be a good idea to see if you need a referral from your primary care physician before receiving treatment. Getting information like this in advance ensures that you will not receive any unexpected bills and will keep you informed of what your financial responsibilities are.

❖ Set Up An Appointment

Get out your planner or calendar to make it easier to choose days and times that work well for you. * If you are seeking care because of an auto accident or work related incident please tell us right away. You will need to keep copies of all receipts and information that you are given and may be called upon to hand over copies of these papers to a lawyer or insurance agency, depending on the circumstances. It might be a good idea to create a folder or notebook to keep all of these things together and in order.

❖ Arrive Early

If you are a new patient, you will need to fill out paperwork. You can get most of it done ahead of time in the comfort of your own home by printing the patient registration and health history packets on our website. Be sure to have your insurance card handy so a photocopy can be made.

When it comes to health care, you don't want to worry about the unknown at your first visit.

All advance preparation can help you feel comfortable and relaxed as you meet with

a specialist and take the first steps to feeling better.

PLEASE BRING THE FOLLOWING WITH YOU TO YOUR FIRST APPOINTMENT:

- □ Your completed new patient forms
- □ A prescription from your Doctor and referral from your Primary Care Physician if required by insurance.
- □ Your Insurance Card
- □ Your Co-Pay or Payment- Payment is expected at the time services are rendered.
  We accept cash, check, Visa and MasterCard
- □ Any written reports of test results you may have had such as x-rays or MRI's.
- □ Please wear comfortable clothing, loose exercise-oriented clothing such as
  T-shirts, sweatpants and sneakers are recommended. If you are coming to us for a knee or
  lower extremity condition, please bring a pair of shorts or wear pants that are easy to roll up.
- □ A list of your prescribed medications. (Dosage, Frequency, Route, Reason for taking)

HOUGHTON PHYSICAL THERAPY

PATIENT INFORMATION FORM

Please print and complete ALL items. If an item doesn't apply, put N/A

Patient Name: _____ Age: _____
Last First Middle

Address: _____
Street City State Zip

Home Phone: _____ Work Phone: _____Cell Phone: _____

Your Email: _____

Social Security #: _____ Sex: _____Date of Birth: _____/_____/_____

Your Employer Name and Address: _____Phone:_____

Occupation: _____ Marital Status: _____ Spouse's Name: _____

****

Referring Doctor: _____***Phone:*** _____

Address: _____ ***Next Dr. Appt:*** _____/_____/_____

Primary Care Doctor: _____ ***Phone:*** _____

Address: _____ ***Last Dr. Appt:*** _____/_____/_____

Person to notify in case of emergency:

Name: _____ Home Phone: _____ Work Phone: _____Relation:_____

Address: _____
Street City State Zip

Who referred you to Houghton Physical Therapy? **We would like to thank them by entering them in our $50 Grocery card Raffle.**

Name: _____ **Email:** _____**Phone:** _____

****

PRIMARY Insurance Company: _____Phone #: _____

Policy Holder's Name: _____
last first middle

DOB_____ Policy #:_____ Group #: _____

Address: _____
Street City State Zip

Policy Holder's Employer: _____

Employer's Address: _____
Street City State Zip

Position: _____Phone: _____

****

Is there Secondary Insurance? Yes _____ No _____

Name of Secondary Insurance Company: _____

Policy #:_____ Group#_____

****

IS THIS A WORKER'S COMPENSATION CLAIM? Yes ___ No ___ Date of Injury: _____Company: _____

Address: _____Phone Number: _____Claim #: _____Contact Person: _____

Is there an attorney involved in your case? Yes _____ No _____

Attorney's Name: _____Phone: _____

Address: _____
Street City State Zip

****

IS THIS AN ACCIDENT CASE? Yes ___ No ___ VEHICLE ___ OTHER _____Date of accident or loss: _____

Insurance Company to Bill: _____

Address: _____
Street City State Zip

Phone #: _____Claim #:_____

Adjuster Name: _____

_____ (initial) HOUGHTON PHYSICAL THERAPY AND SPORTS CONDITIONING NOTICE OF PRIVACY PRACTICES: At the time of my appointment I was offered a copy of the "NOTICE OF PRIVACY PRACTICES" (HIPAA) and also was given a copy to read explaining my privacy rights.

I hereby authorize HOUGHTON PHYSICAL THERAPY, LLC. to furnish information to the insurance carriers concerning my treatment and hereby assign to the therapist(s) all payments for service rendered. I understand that I am responsible for all charges, even those not paid by my insurance. I understand that by signing I am giving my permission for treatment. I also authorize Houghton Physical Therapy, LLC. to contact the insurance commissioner on my behalf, to assist me in receiving my full insurance benefits, if deemed necessary.

SIGNATURE: _____ DATE: _____

Signature for Minor (under 18 years of age) _____

RECEPTIONIST INITIALS _____

HOUGHTON PHYSICAL THERAPY
FINANCIAL POLICY

TO OUR VALUED PATIENTS:

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, **we need your assistance**, and your understanding of our payment policy.

Payment for services is due on each visit for charges incurred up through your last visit. We accept cash, checks, MasterCard, or Visa. We bill electronically, to expedite payment of claims.

Please read carefully:

1. Your insurance is a contract between you, your employer and your insurance co. We are not a party to that contract.

2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of U.C.R. "U.C.R." is defined as usual, customary and reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees, which bears no relationship to the current standard and cost of care in this area.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. These particular services, if any, are your responsibility.

4. **Medicare patients are responsible for the yearly deductible and if Medicare is the only insurance you are responsible for 20%.**

5. If this injury is work related, and a Workers Compensation claim has been initiated, you are given 10 visits with no claim number, if after the 10th visit, a claim number has not been received, or your case is denied by WC, then you are responsible for each additional visit. **We require, on your initial visit, that you provide us with your medical insurance to insure payment of the account if your case is not allowed. If you already have a claim number, please provide us with the number on the registration form.** If you have an attorney, please provide this information on the registration form.

6. For liability cases, where another party is responsible, you need to provide us with all the billing information. If you have an attorney, please provide this information on the registration form. It is this office's policy that a letter of protection, also known as a lien must be received from your attorney within the first 2 weeks of your treatment. Without this letter, you become responsible for the account in full.

Again, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us.
We are here to help you!

I have read the above policies and agree.

SIGNATURE: _____ **DATE:** _____

HOUGHTON PHYSICAL THERAPY AND SPORTS CONDITIONING
80 Park St. Attleboro, MA 02703
Phone: (508)223-2300 Fax: (508)223-2340

Patient's History of Current Injury/Illness

Mailing Address: P.O. Box 865
Attleboro, MA 02703

Name: _____ **Today's Date**: _____

Age: _____ **Date of Birth**: _____ **Sex**: _____ **Marital Status** _____ **# Children** _____ **Ages**_____

Occupation: _____ **Right** or **Left** handed **Height**._____ **Weight**. _____

Have you ever been a patient here before? Yes_____ No _____; If yes, for the ____same or ____different problem?

Please indicate for which body region you are seeking treatment:

__Neck __Mid Back __Low Back __Shoulder __Elbow __Hand/wrist __Hip __Knee __ Ankle/foot __ Other

When did your symptoms start? Date _____ Can you identify a cause for your symptoms? Yes_____ No _____

If yes, specify: _____

Have you ever had similar symptoms in the past? Yes ____ No ____ If **yes**, when? _____

Have you recently had the following tests? Yes ____ No____ If **yes**, check all that apply:

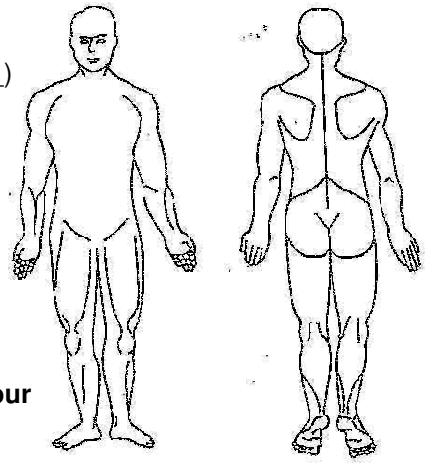
____X-rays	____Bone Scan	____Myelogram	____ EKG
____CT Scan	____EMG	____Stress Test	____Echocardiogram
____MRI	____Blood Tests	____ Pulmonary Function Test	____Other (Please list)_____

Pain rating*:* Indicate your average level of pain by circling the appropriate number on the scale below:

0 1 2 3 4 5 6 7 8 9 10

Pain free *Unconscious Pain*

PLEASE USE THE BODY DIAGRAM AND *SHADE AREAS OF PAIN* →



Describe the character of your pain? (Circle one - sharp, dull, achy, other _____)

Is the pain there all the time (constant)? Yes _____ No _____

Does the pain move or radiate anywhere? Yes _____ No _____

If yes, describe location of radiation or numbness _____

Do you have numbness, tingling, or weakness? Yes _____ No _____

If yes, please describe: _____

Have you had any changes in your bowel, bladder or sexual function as a result of your symptoms? Yes ___ No ____ Describe_____

What activities/positions make your pain worse?_____

_____

What activities/positions make your pain better? _____

_____

Have you previously seen or currently seeing any other health care provider for this problem? ____ Yes ____No

___Physician ___Osteopath ___Podiatrist ___Other (Please list below)

___Physical Therapist ___Chiropractor ___Dentist _____

Have you been discharged from the hospital, a skilled nursing facility, or Home Health Agency in the past 30 days related to this condition? Yes ___ No ____ If yes, please describe: _____

Please circle those treatments listed below that have been tried in the past:

___Physical Therapy ___Chiropractic ___Acupuncture ___Braces ___Collars ___Tens Unit ___Injections

___Medications ___None ___Other (please describe):_____

HOUGHTON PHYSICAL THERAPY AND SPORTS CONDITIONING

Patient Name: _____

Medical History

Allergies	Y	N	Dizzy Spells	Y	N	MRSA	Y	N
Anemia	Y	N	Emphysema/Bronchitis	Y	N	Multiple Sclerosis	Y	N
Anxiety	Y	N	Fibromyalgia	Y	N	Muscular Disease	Y	N
Arthritis	Y	N	Fractures	Y	N	Osteoporosis	Y	N
Asthma	Y	N	Gallbladder Problems	Y	N	Parkinsons	Y	N
Autoimmune Disorder	Y	N	Headaches	Y	N	Rheumatoid Arthritis	Y	N
Cancer	Y	N	Hearing Impairment	Y	N	Seizures	Y	N
Cardiac Conditions	Y	N	Hepatitis	Y	N	Smoking	Y	N
Cardiac Pacemaker	Y	N	High Cholesterol	Y	N	Speech Problems	Y	N
Chemical Dependency	Y	N	High/Low Blood Pressure	Y	N	Strokes	Y	N
Circulation problems	Y	N	HIV/AIDS	Y	N	Thyroid Disease	Y	N
Currently Pregnant	Y	N	Incontinence	Y	N	Tuberculosis	Y	N
Depression	Y	N	Kidney Problems	Y	N	Vision Problems	Y	N
Diabetes	Y	N	Metal Implants	Y	N	Other	Y	N

Describe Any Other Conditions or Explain Above Conditions:_____

_____

_____

Fall History

Is this injury a result of a fall in the past year? **Y** / **N** Have you had two or more falls in the last year? **Y** / **N**

Surgical History □ Check here if a surgical history was provided When (MM/DD/YYYY

Surgery Type: _____ Date:_____/ ____/____

Surgery Type: _____ Date:_____/ ____/____

Surgery Type: _____ Date:_____/ ____/____

Surgery Type: _____ Date:_____/ ____/____

Current Medications	**Dosage**	**Frequency**	**Route Oral/ Inhale**	**Reason for Taking:**
Ex: Ibuprofin	800ml	2x day	Mouth	Pain

□ Check here if a medication list was provided □ Check if you need to continue on back

Job Description/Social Activites (physical tasks, amount of sitting, lifting, computer work, etc.): _____

_____

What are your goals for your course of physical therapy?_____

_____

At the present time, would you say your health is excellent, very good, fair, or poor? _____

Patient Signature: _____ Date:_____