Back to You
Physical Therapy & Sports Medicine

19 North Main Street, Suite 1A
Sherborn, MA , 01770
p. 508. 545. 2352 f. 508. 545. 2354

PLEASE PRINT CLEARLY AND COMPLETE ALL ITEMS FOR PROPER PROCESSING OF YOUR CLAIM

SEC 1

NAME _____ _____ _____ SEX ☐ M ☐ F
FIRST MI LAST

ADDRESS _____
STREET APT.# CITY STATE ZIP

PHONE _____ MOBILE _____ D.O.B. _____

EMAIL _____

EMERGENCY CONTACT _____ PHONE _____

SEC 2 ***HOW DID YOU HEAR ABOUT US?***

☐ MD REFERRED _____ ☐ MD REFERRAL LIST ☐ INSURANCE CO. WEBSITE
PHYSICAN'S NAME

☐ SIGN/DRIVING BY ☐ FORMER PATIENT _____
PATIENT NAME

☐ FACE BOOK/ NEXT DOOR ☐ INTERNET SEARCH ENGINE (GOOGLE, YELP)

SEC 3 ***HEALTH COVERAGE***

PRIMARY INSURANCE _____ PCP _____
(NAME) (PRIMARY CARE PHYSICIAN)

SUBSCRIBER _____ PCP TOWN _____

SEC 4 ***TYPE OF INJURY***

IS THIS INJURY RELATED TO AN ACCIDENT AT WORK? OR AN AUTO ACCIDENT? ☐ YES ☐ NO

PROTECTED HEALTH INFORMATION CONTACT CONSENT

I CONSENT TO RECEIVE APPOINTMENT REMINDERS VIA TEXT AND EMAIL, AND OTHER HEALTHCARE COMMUNICATIONS/ INFORMTION AT THE EMAIL ADDRESS AND/OR PHONE NUMBERS PROVIDED ABOVE _____ PATIENT INITIALS

SEC 5 ***CONSENT FOR TREATMENT***

I THE UNDERSIGNED, A PATIENT OF BACK TO YOU PHYSICAL THERAPY & SPORTS MEDICINE INC., DO HEREBY CONSENT TO TREATMENT AS PRESCRIBED BY MY PROVIDER, A LICENSED PHYSICAL THERAPIST IN THE STATE OF MASSACHUSETTS.

I HAVE READ AND UNDERSTAND THE CONSENT FOR TREATMENT _____ PATIENT INITIALS

SEC 6 ***HIPAA NOTICE OF PRIVACY PRACTICES***

WE ARE REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF OUR PATIENTS, AND PROVIDE INDIVIDUALS WITH A NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO PROTECTED HEALTH INFORMATION. YOUR SIGNATURE BELOW IS TO ACKNOWLEDGE THAT YOU HAVE BEEN GIVEN A NOTICE OF OUR PRIVACY PRACTICES.

_____ _____
PATIENT SIGNATURE DATE

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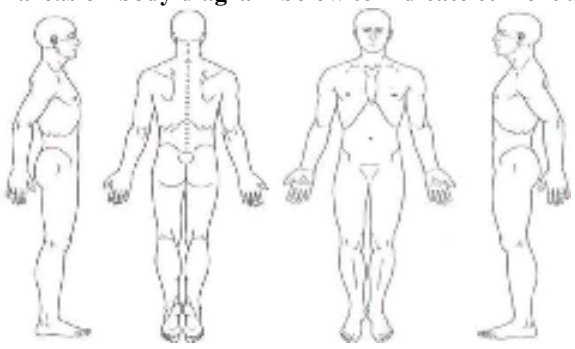
PATIENT HEALTH QUESTIONNAIRE

Name:_____ Date of Birth:_____Age:_____Right / Left Hand dominant

Please shade in areas on body diagram below to indicate current areas of pain:



What is the reason for your visit? _____

Have you had Physical Therapy in last 12 months? **YES** or **NO** How many visits? _____

Have you had Home Care? **YES** or **NO** If YES, what was Discharge date ___/___/____

Are your symptoms: □ Improving □ Getting Worse (Evolving and/or Changing) □ Staying the Same □ My pain is different depending on the activities □ My pain (fluctuates in intensity and duration, is unpredictable)

Height _____ Weight _____

Have you had x-rays, MRIs, or other special tests performed for your current problem? **Yes / No** Please give dates and results.

_____

_____

Are you currently pregnant? **Y / N** Do you have allergies/**latex sensitivity**? _____

Medical History (check conditions that may apply)

___ Arthritis
___ Broken bones/fractures
___ Osteoporosis
___ Circulation/vascular problems
___ Heart Problems
___ High blood pressure
___ Pacemaker/Defibrillator
___ Stroke
___ Diabetes
___ Headaches
___ Lung problems
___ Other:_____

___ Low blood sugar/hypoglycemia
___ Head injury
___ Multiple Sclerosis
___ Bowel or Bladder problems
___ Parkinson's Disease
___ Seizure/epilepsy
___ Developmental/growth problems
___ Thyroid problems
___ Dizziness
___ Cancer (type) _____

___ Tuberculosis
___ Hepatitis, HIV+, infectious disease
___ Shortness of breath/chest pains
___ Unexplained weight loss/gain
___ Ulcers/stomach problems
___ Vision problems
___ hearing problems
___ Balance problems, history of falls
___ Nausea/vomiting
___ Depression

List all past surgeries (month/year)_____

_____

List all medications you are currently taking_____

_____

_____

_____

Patient Signature:_____**Date:**_____

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Credit Card Authorization on File Form

In order to facilitate contactless checkout during the COVID-19 pandemic, we ask that you place a card on file. This will allow us to charge any insurances copayments and or deductibles per visit if required, based on your individual insurance plan. Our office manager will review your insurance benefits with you on your first treatment via our financial agreement. If you do not wish to place a card on-file, please contact our office manager to discuss other payment options. Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐Other

Cardholder Name (as shown on card): _____

Card Number: _____

Expiration Date (mm/yy): _____

Cardholder ZIP Code (from credit card billing address):
_____

CVV code: _____

I, _____, authorize Back to You Physical Therapy & Sports Medicine to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____
Customer Signature Date

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Protected Health Information Policy

Consent to Email, Phone Call, or Text Usage for Appointment Reminders and Other Healthcare Communications:

Patients of Back to You Physical Therapy & Sports Medicine Inc. may be contacted via email, phone call, and/or text messages to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/personal health information. If at any time you provide an email or text address at which you may be contacted, you provide your consent to receiving appointment reminders and other healthcare communications/information at that email or text address from Back to You Physical Therapy & Sports Medicine. You also provide your consent to receive text messages from Back to You Physical Therapy at your cell phone and any number forwarded or transferred to that number, or from emails to receive communication as stated above. You understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless you request a change in writing. Back to You Physical Therapy does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Secure and encrypted communication options:

Emails with more sesnsitive protected health information can be encrypted upon request. Patients can communicate any Protected Health information or message your provider through our secure patient portal. Login link available upon request.

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

OUR COMMITMENT TO YOUR PRIVACY

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at our office and that are otherwise brought to our attention. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this office's personnel.

USES AND DISCLOSURES: We will use and disclose elements of your protected health information in the following ways without your signed authorization:

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. If necessary, information may be used for an outside collection agency to collect any balance due to this facility.

Health Care Operations: Your health information may be used as necessary to support the day-to-day activities and management of Back to You Physical Therapy & Sports Medicine, Inc.

Law Enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government-mandated reporting.

Appointment Reminders: Our practice may use and disclose your personal health information to contact you to remind you of a scheduled or missed appointment. We will also use your health information to confirm your first appointment with this facility.

OTHER USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Individual Rights: You have certain rights under the federal privacy standards. These include the right to:

•request restrictions on the use and disclosure of your protected health information. This must be done in writing, dated and signed by you.

•receive confidential communications concerning your medical condition and treatment by alternate means. This must be described in writing and signed and dated by you.

•inspect or receive copies of your protected heath information. This requires a signed and dated request and payment for the copies.

•amend or submit corrections to your protected health information. This must be a signed and dated request that we are not required to grant.

•receive an accounting of how and to whom your protected health information has been disclosed. This must be a signed and dated request.

•receive a printed copy of this notice at your request.

Duties of Back to You Physical Therapy & Sports Medicine, Inc.: We are required by law to maintain the privacy of your protected health information and to provide you with this notice of our privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Complaints: If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to either Back to You Physical Therapy & Sports Medicine, Inc. If you believe that your privacy rights have been violated, you should call the matter to our attention or may also contact the U.S. Department of Health and Human Services. You will not be penalized or retaliated against for filing a complaint.

Effective Date: This notice is effective on or after April 1, 2011.

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