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 _____ _____ _____ ☐ She/Her ☐ He/Him ☐ They/Them
FIRST MIDDLE LAST PREFERRED GENDER PRONOUN

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