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***

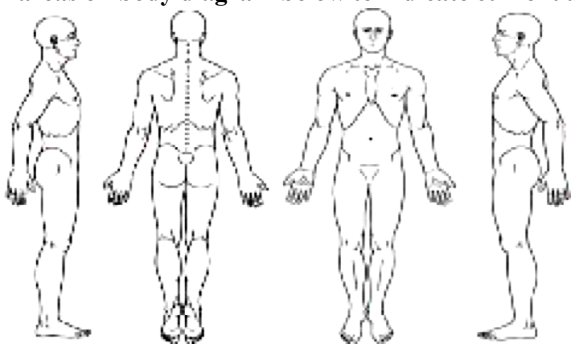
IS THIS INJURY RELATED TO AN ACCIDENT AT WORK? OR AN AUTO ACCIDENT? ☐ YES ☐ NO

Back to You
Physical Therapy & Sports Medicine

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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PROTECTED HEALTH INFORMATION CONTACT CONSENT

I consent to receive appointment reminders via text and email, and other healthcare communications/information at the email address and/or phone numbers provided.

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.

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.

CANCELLATION POLICY

All cancellations made less than (<)One (1) business day of your appointment time,
***regardless of reason*, will incur a $50 cancellation fee.**
Appointment reminders are sent 48 hours in advance via text, email, voice message, and/or phone. Business days are Monday through Friday (we are closed on the weekend).

Cancellation fees will be charged without exception, regardless of reason

I understand I will be charged a $50 fee for a late cancellation or missed appointment.

CONSENT TO BILL MY INSURANCE

I hereby authorize and direct my insurance carrier to issue the expense benefit allowed and payable to me under the terms of the insurance policy as payment for services rendered to me by BACK TO YOU PT.

I also hereby authorize and direct BACK TO YOU PT to release any and all information from my medical records related to my condition in order to process the claims. I agree to promptly notify this clinic of any change in my insurance information until my account is paid in full.

I have read and consent to all of the above.

Patient / Legal Guardian (signature): _____ **Date:**_____

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FINANCIAL AGREEMENT

BACK TO YOU PHYSICAL THERAPY is devoted to providing you with the best possible care. If you have health insurance, we are committed to helping you receive your maximum allowable benefits. We must emphasize that as health care providers, our relationship is with you, not your insurance company. 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.

- ☐ I understand that it is my responsibility to comply with the guidelines set by my insurance company.
- ☐ I understand that all co-payments are due that the time of service and that all deductibles, copays/coinsurances, and non-covered charges are due within 30 days upon receipts of invoice.
- ☐ I accept full responsibility for payment of services and/or for securing necessary primary care referrals or pre-approval for medical visits. If applicable, I understand that I have an obligation to obtain a referral for physical therapy services from my primary care physician (PCP) prior to having service rendered. I acknowledge that if the appropriate referral/authorizations are not on file at the time services are rendered, that I am financially responsible for any charges denied by the health insurance carrier as a result (We will help you with this to the best of our ability).
- ☐ I accept full responsibility for payment of services should insurance not pay for said rendered services. I understand that if I exceed my maximum permitted visits per my insurance plan benefits that I am liable for the cost of treatment and any additional services.
- ☐ If uninsured or paying out of pocket, I understand that full payment for all services is due on the date of service.
- ☐ I understand that future appointments may be contingent upon having met my financial obligations within the office or having made appropriate arrangements with BACK TO YOU PHYSICAL THERAPY (ex. payment plan).
- ☐ I understand I will be charged a $50 fee for a late cancellation or missed appointment.

I have read and consent to all of the above.

Patient / Legal Guardian (signature): _____ Date: _____

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