BLACKSTONE VALLEY PHYSICAL THERAPY SERVICES, INC.
670 Linwood Ave. Suite 2 Whitinsville, MA 01588
P: (508) 234-7544 F: (508) 234-8002
www.bvpts.com

New Patient Registration Packet

Name: _____ Preferred name: _____
First MI Last if other than your first name

Address: _____
Street Address City/Town State Zip Code

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Primary Phone: □ Home □ Work □ Cell E-mail: _____@_____

Date of Birth: ___/____/____ Marital Status: □ Single □ Married □ Divorced/Separated □ Other:_____

Occupation:_____ □ Employed F/T □ Employed P/T □ Retired □ Student □ Other

Emergency Contact Name/Relation:_____/_____ Phone (____)_____

Primary Care Physician: _____ Referring Physician: _____

Primary Health Insurance Co. & # : (if card isn't present)_____

Name of Subscriber (if not patient): _____

Subscriber's Date of Birth: ____/____/_____ Subscriber's employer: _____

Secondary Health Insurance Co. & #: _____

Are your injuries a result of a motor vehicle accident? No ___ Yes, Date of accident __/___/____
Are your injuries a result of a worker's compensation accident? No ___ Yes, Date of injury __/___/____
Employer_____

If the answer to either of the above questions is yes, please provide our office staff with the following information so that we can bill the appropriate company for your physical therapy services:

Ins. Co. Name:_____ Adjuster:_____ Claim #:_____

Phone:_____ Fax: _____ Address: _____

How did you hear about us? Please check all that apply :

□ Friend/Family referral (whom should we thank): _____
□ Medical/Physician referral: _____ □ Uxbridge Times Ad □ Internet search
□ Golf Advertisement □ Social Media □ Website □ Sports sponsorship □ Insurance referral
□ Other_____ □ Wellness programming (Classes, etc)

 Please Initial: _____

Informed Consent for Physical Therapy Treatment

I, hereby agree to a physical therapy evaluation and routine treatment by a Massachusetts licensed physical therapist or under his/her supervision, a Massachusetts licensed physical therapy assistant. I understand that the physical therapy treatment will be provided for the identification, prevention, remediation, and rehabilitation of an acute or chronic physical dysfunction. I understand that my physical therapist/physical therapist assistant will have me involved in the decisions of my care at all times. My consent to any treatment set forth is voluntary and I may withdraw any such consent at any time and to any aspect of the prescribed treatment.

Benefits to be expected
Although no assurance can be given and every case is individual, common benefits associated with regular participation in a physical therapy program include, but are not limited to, improvement in joint range of motion/flexibility, muscle strength, cardiovascular endurance, physical performance, body mechanics, decreased pain levels, and reduction in future injury risk with the primary goal to restore maximum functional independence.

Risks and Discomforts
As with any medical procedure or treatment there are risks. These include abnormal blood pressure, fainting, disorders of heart rhythm, excessive perspiration and, in very rare instances, heart attack, stroke or death. Every effort will be made to minimize those risks by the initial examination/evaluation and by observations during the therapy sessions. If you have any concerns or questions about a particular portion of the proposed treatment, please notify your physical therapist or physical therapy assistant and he/she will address these issues.

Your responsibility as a patient
To gain the expected benefits of treatment, you must give priority to regular attendance and adherence to prescribed amounts of intensity, duration frequency, progression and type of activity and will report any unusual symptom(s) which you may experience before, during, or after a physical therapy treatment session.

I have read, or have had read to me the above consent. By signing below, I agree to, or agree to have my child, receive routine physical therapy treatment as explained to me by the treating physical therapist. My signature also attests to the fact that I have been given Patient's Rights and Responsibilities and Notice of Privacy Practices and been given ample opportunity to review it. I intend this consent to cover the entire course of treatments for my condition for which I seek treatments from BLACKSTONE VALLEY PHYSICAL THERAPY SERVICES, INC.

_____ _____
Print patient name Date

_____
Patient Signature (Parent or Guardian if patient is less than 18 years of age)

Authorization to Release Information/Record Requests

In order to make informed decisions regarding your physical therapy treatments, it is helpful for your physical therapist to have access to your medical records. By initialing the box below, you authorize release of your medical, hospital, or surgical records to BVPTS pertinent to your physical therapy treatment, including but not limited to imaging, exams, surgical reports, special tests, or lab results. In addition, I authorize the release of my physical therapy treatment information to insurance companies or attorneys as needed to facilitate approval or payment, with the exception of the following:

_____

_____ _____
Print patient name Date

_____
Patient Signature (Parent or Guardian if patient is less than 18 years of age)

Payment Information

We are pleased that you chose us for your physical therapy care. We are hopeful that your experience with us will be outstanding from start to finish. The following is some information in regard to the finances of your visit.

PAYMENT POLICY

Payment for physical therapy treatment is **ultimately the responsibility of the patient**. We will bill your health insurance as a courtesy, and will notify you if we anticipate any issues with benefits, however with the increased complexity of various policies, you are encouraged to contact your health insurance carrier to find out what your physical therapy benefit, or coverage is, based on your policy as well as any patient responsibility. Should your health insurance coverage expire or terminate while you are still being treated, let us know and further options can be discussed. Please note, we do NOT determine deductible or co-pay rates; this is determined by your policy.

CO-PAYMENTS, CO-INSURANCE, AND DEDUCTIBLES

Our front office will attempt to verify your physical therapy insurance benefits prior to your first visit. This will be reviewed with you on your first visit, if possible. We require that **payments be paid at the time that our services are rendered**, unless other arrangements have been made. Most plans require a co-payment or co-insurance per visit, and many plans now include deductibles. For those that haven't met their deductible, we encourage you to make a payment at each visit to avoid accruing a large balance, and once the explanations of benefits (EOB's) are received, we will review the balance and adjust your account accordingly. For your convenience, we offer the ability to leave a **credit card securely on file** in our PCI-DSS version 3.2 system, and not require a card to be present at each visit. Please fill out the information below to take advantage of this opportunity. Patients will be made of any charges, and offered a receipt. Patients can revoke this authorization by submitting a written request at any time. Cash, check and MasterCard/Visa/ Discover are accepted forms of payment at this time. There is a $20.00 minimum fee on returned checks.

Credit Card Authorization

Card Type	□ Visa □ Mastercard □ Discover
Cardholder name	
Last 4 digits on account	
Cardholder Zip	

I, _____, authorize BVPTS to charge this credit card for co-payment, co-insurances, remaining balances, payment plans, and cancellation/no-show fees. I understand my information will be securely saved electronically for future transactions on this account. I understand this authorization will remain in effect until cancelled and may be cancelled at any time by submitting a request in writing.

_____ _____

Patient Signature (Parent or Guardian if patient is less than 18 years of age) Date

Medicare patients – I hereby certify that all information given by me in applying for payment under the title XVII of the Social Security Administration or it's intermediaries or carriers any such information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I understand that I am responsible for any health insurance deductibles and co-insurance.

Workers Compensation and MVA patients – We will bill 3rd party payers as courtesy, however we may need you to actively assist in communication with responsible parties to obtain payment for services rendered.

ASSIGNMENT AND RELEASE – I hereby authorize and direct my insurance benefits for PT to be paid directly to BLACKSTONE VALLEY PHYSICAL THERAPY SERVICES, INC. I understand that I am financially responsible for co-payments, balances, deductibles, or any non-covered services.

Print Name: _____ Relation to Patient: _____

Signature: _____ Date: _____

COLLECTIONS

Our billing company will send out monthly statements for patients with a balance. The patient is responsible for any collection costs, should the use of a collections agency be required to receive payment on your account. Patients will be charged a $30 fee for billed balances that are delinquent at 90 and 120 days. Payment plans are available on a case by case basis.

_____ _____

Print patient name Date

_____

Patient Signature (Parent or Guardian if patient is less than 18 years of age)

ATTENDANCE POLICY

We are aware that at times you may be unable to attend your scheduled visits. As a courtesy, we ask for at least **48 hours notice** if you need to cancel your visit. This will allow us to provide care to another patient that may be waiting for treatment. Attendance of your scheduled visits is critical to allow us to consistently treat you and maximize your gains from physical therapy. Your physical therapist will review with you our Attendance Policy on your first visit. There is a $30 charge for cancellations within 48 hours or no-shows. In addition, if multiple visits are missed, in order to prevent you from incurring additional charges, we may have you call on the days you can make to schedule visits.

_____ _____

Print patient name Date

_____

Patient Signature (Parent or Guardian if patient is less than 18 years of age)

TELEHEALTH (optional)

In some cases, patients can benefit from the use of Telehealth physical therapy visits to complete their require sessions and plan of care. During the telehealth consultation(s), details of your medical history, examinations, diagnostic imaging/testing will be reviewed and discussed with your physical therapist through the use of HIPAA secured video and audio telecommunication technology. Your physical therapist will perform an evaluation or treatment by instructing you in a series of motions as well as observing you complete prescribed exercises with the intent of making sure proper technique is being performed.

Any existing laws and policies regarding your access to medical information and copies of your medical records will apply to this telehealth evaluation and subsequent treatments. No video recording will be made without your knowledge and any dissemination of any patient identifiable images or information for this telehealth interaction to any other parties or entities shall not occur without your consent. Still photos may be taken with your consent. We try to assure all reasonable and appropriate efforts have been made to eliminate any confidential risks associated with your telehealth consultation but using HIPAA compliant Telehealth software. All existing confidentiality protections under state and federal law apply to information disclosed during this telehealth evaluation or treatment.

You may withhold or withdraw your consent to the telehealth at any time without affecting your right to future care or treatment. You have been advised of all the potential risks, consequences and benefits of telehealth.

I hereby do agree to participate in telehealth physical therapy evaluation and treatments with Blackstone Valley Physical Therapy per the conditions above.

_____ _____

Print patient name Date

_____

Patient Signature (Parent or Guardian if patient is less than 18 years of age)

VALUABLES
Blackstone Valley Physical Therapy Services, Inc. is not responsible for any personal property or valuables brought into the facility, and we recommend only bringing in what is necessary for treatment.

HIPAA REGULATIONS
BVPTS complies with Health Insurance Portability and Accountability Act ("HIPAA"), will protect my Protected Health Information (PHI), and will use it as allowable by law in the treatment, billing, and collections in regard to my treatment until my case is closed and full payment has been received. I authorize the release of information pertinent to my case to any insurance company, adjuster or attorney for the purpose of securing payment under this policy of insurance or to any Medical Provider associated with my case to effectively provide treatment. This Authorization will last for 3 months after the final payment is received.

In order to ensure that our patients receive time-sensitive information and other informational healthcare messages, BVPTS will send notifications to patients that opt-in to receive such notifications. If you choose to sign this consent and opt-in to receive such notifications from BVPTS, we will not impose a separate charge for these notifications; however, depending on the terms and conditions of your wireless carrier contract and/or plan, fees and/or restrictions may be imposed upon you form your wireless carrier. Please contact your wireless carrier regarding these fees and/or restrictions prior to providing your consent herein to receive notifications from BVPTS. Please note that some communications, including, without limitation email and/or text message, which may contain your protected PHI, are not invariably secure since some messages may can be intercepted, delivered and/or addressed to an unintended recipient, and/or improperly accessed while in storage and/or during transmission. In compliance with the HIPAA, we are required by law to maintain the privacy and security of your PHI. In addition, pursuant to the HIPAA Privacy Rule and BVPTS' Notice of Privacy Practices, we will not use and/or disclose your PHI without your explicit written authorization, except as permitted by law for the purposes of payment, treatment and health care operations. Furthermore, when we are authorized and/or permitted to use and/or disclose your PHI, we will limit the use and/or disclosure of your PHI to the minimum amount necessary to accomplish the intended purpose of the use and/or disclosure of your PHI. You have the right to revoke this consent by providing written notice of revocation to the Privacy Officer at BVPTS. The revocation will become effective on the day the Privacy Officer receives the revocation of the consent, and any prior notifications from BVPTS will not be subject to such revocation of the consent.

I, the undersigned, hereby consent to receive notifications from BVPTS, which notifications may include my PHI, by the following methods of communication that I indicated below, with a full understanding of the risks involved with such notifications from BVPTS, and I agree to assume all responsibility for informing BVPTS in writing of any changes to any of the methods of communications that I indicated below and for ensuring that the methods of communication that I indicated below are secure, with password protection used where applicable, and I further agree that BVPTS shall not be held liable for any unauthorized disclosures of my PHI to a third party through any of the methods of communication I authorized below or for any fees and/or restrictions that may be imposed upon me for receiving notifications from BVPTS:

☐ Text Message*: (_____)_____ ☐ E-Mail:_____

☐ **Opt-out of receiving text message and email communications from BVPTS**

*wireless carrier's standard message rates, data rates, and/or restrictions may apply, and by consenting to receive notifications from BVPTS **you agree to be solely responsible** for all fees that you incur from receiving notifications from BVPTS.

Print Name: _____ Relation to Patient: _____

Signature: _____ Date: _____

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Medication List

Patient Name: _____ Initial Date Completed:_____

Please list all prescription medication, over the counter medication, herbals, or vitamin/dietary supplements you are presently taking.

Medication Name	Dosage	Frequency [Circle which applies]	Route [Circle which applies]
		Once/day / Twice/day Other:	Oral / Injection
		Once/day / Twice/day Other:	Oral / Injection
		Once/day / Twice/day Other:	Oral / Injection
		Once/day / Twice/day Other:	Oral / Injection
		Once/day / Twice/day Other:	Oral / Injection
		Once/day / Twice/day Other:	Oral / Injection
		Once/day / Twice/day Other:	Oral / Injection
		Once/day / Twice/day Other:	Oral / Injection
		Once/day / Twice/day Other:	Oral / Injection
		Once/day / Twice/day Other:	Oral / Injection
		Once/day / Twice/day Other:	Oral / Injection
		Once/day / Twice/day Other:	Oral / Injection

Signature: _____

Updated on: _____, _____, _____, _____, _____

 Please Initial: _____

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Medical History and Present Condition

Name: _____ Age: _____ Gender: M F Height:__ft __in Weight:_____

WHAT is your current complaint (pain/symptoms) & **WHEN** did it begin?		
HOW did your current compliant begin? How did you get hurt?		
Have you received any X-rays or MRI related to your injury?	Yes or No Please circle	If Yes, When: Where:
Have you had any surgeries in the past?	Yes or No Please circle	Please specify the procedure(s) & date(s):
Have you had physical therapy in the past year?	Yes or No Please circle	Where, when, for what, & how many visits:
Do you have any allergies we should be aware of?	Yes or No Please circle	Please list
What is your current exercise program?		

Please check if you or a family member has experienced any of the following conditions:

Medical History	Patient	Family	Medical History	Patient	Family
Anxiety/Depression			Heart Attack/Surgery		
Asthma/Hay Fever			Immune Deficiency/Disease		
Arthritis			Recent Infection		
Back injury or pain			Joint Replacement Surgery		
Cancer/Tumor			Kidney Disease		
Chest Pain			Liver Disease/Hepatitis		
Clotting/Bleeding Disorder/DVT			Lung Disease/COPD/Tuberculosis		
Concussion or Brain Injury			Osteoporosis		
Convulsions/Epilepsy			Neck Injury or pain		
Diabetes			Neurological Disease/Stroke		
Eye Issues/Glaucoma/Cataract			Pace Maker/Defibrillator		
Fractures			Skin Disorders/Psoriasis		
Fever/Chills/Sweats			Are you a Smoker		
Fibromyalgia			Thyroid Disease		
Headaches			Unexplained weight changes		
High Blood Pressure/Hypertension			Vertigo/Vestibular Issues		
High Cholesterol/Hypercholesterolemia			OTHER:		

Please Initial: _____

What makes the pain/symptoms increase? □ Work □ Sports □ Standing □ Sitting
□ Lying Down □ Housework □ Yardwork □ Lifting □ Reaching □ Dressing
□ Other(s): _____

What makes the pain/symptoms decrease? □ Rest □ Heat □ Standing □ Sitting
□ Lying Down □ Medications □ Sleeping □ Ice □ Exercise □ Stretching
□ Other(s): _____

How often do you have the symptoms? □ Constantly □ Occasionally □ Rarely
□ Only when I _____

Are the symptoms? □ Improving □ Worsening □ Remaining the same

Because of my current complaint I am having difficulty with:_____

_____

What would you rate the pain/symptom level:

At worst, when I _____, the pain is a:

0	1	2	3	4	5	6	7	8	9	10
No pain	Minor		Moderate		Severe				Worst pain ever	

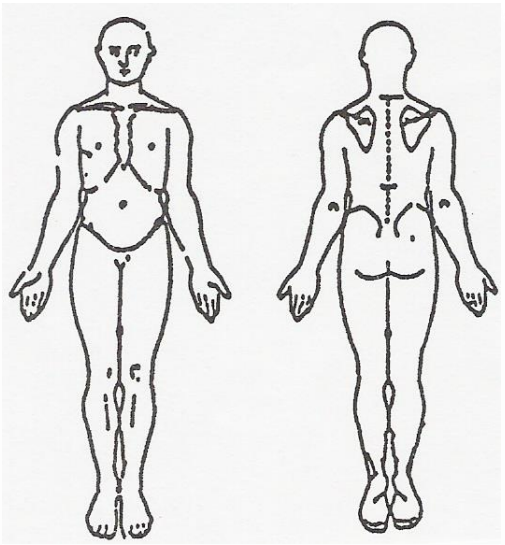
Currently, sitting here, my pain level is a:

0	1	2	3	4	5	6	7	8	9	10
No pain	Minor		Moderate		Severe				Worst pain ever	

At best, when I _____, the pain is a:

0	1	2	3	4	5	6	7	8	9	10
No pain	Minor		Moderate		Severe				Worst pain ever	

Please shade areas of your symptoms below



What are your current goals for physical therapy? (What are you hoping to get out of therapy?)

_____

What is the date of your next physician visit? Referring physician _____
Primary Care physician _____

We can use video for educational, demonstration, and marketing/promotional purposes. We don't require anyone to be recorded, and we will discuss any recording/photographing prior to bringing a camera or other device out. We can use your device as well, if you prefer.

By initialing, I give my written consent to be photographed/videotaped during my treatment for:
_____ My own therapeutic use only (any picture or video will be deleted after review)
_____ I would prefer my own device be used
_____ BVPTS Marketing/Promotional Materials (Website/Social Media/Advertising)

Please share anything else related to your health or physical therapy care we should be aware of:

_____

_____

Please Initial: _____