



Dear Patient:

We would like to take this opportunity to thank you for choosing Beantown Physio, Inc.! We look forward to restoring total wellness to your life.

Each member of our staff went into the health care industry because of a strong desire to help and care for people. We believe that due to this continued aspiration and our success rate, your physician, friend or family member has referred you here.

The practice of physical therapy has certainly changed over the years—these changes are definitely to your personal benefit. Technology and research have given us the ability to progress your level of function at a much quicker rate. With this in mind, however, please remember that medicine is never black and white.

Our phone lines and email are always available if you ever have a question or concern regarding your care. We hope our extensive hours of operation enable you to receive treatment when it is most convenient to your schedule.

Finally, if you are pleased with the service that you receive, please do us a favor and thank your physician, friend or family member who referred you.

***Welcome to Beantown Physio, Inc.***

Sincerely,

The Staff at Beantown Physio

**These forms must be filled out by a parent/guardian for any patient under the age of 18.**

**PERSONAL INFORMATION**

FIRST NAME: \_\_\_\_\_ M.I. \_\_\_\_\_ LAST NAME: \_\_\_\_\_  
STREET ADDRESS: \_\_\_\_\_ APT #: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_  
HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_  
CELL PHONE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_  
SOCIAL SECURITY NUMBER (Mandatory for Medicare patients, otherwise optional): \_\_\_\_/\_\_\_\_/\_\_\_\_  
SEX: \_\_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_  
HOW DID YOU HEAR OF OUR FACILITY? \_\_\_\_\_

**EMPLOYER/ SCHOOL INFORMATION**

EMPLOYER/ SCHOOL NAME: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_  
EMPLOYER ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

**PHYSICIAN/ REFERRAL INFORMATION**

REFERRING MD: \_\_\_\_\_  
PRIMARY CARE PHYSICIAN: \_\_\_\_\_

**PERSONAL HEALTH INSURANCE INFORMATION**

NAME OF PRIMARY INSURANCE COMPANY: \_\_\_\_\_  
POLICY/ ID NUMBER: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_  
SUBSCRIBER NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
RELATIONSHIP TO SUBSCRIBER: \_\_\_\_\_  
DO YOU HAVE SECONDARY INSURANCE? Y OR N  
IF YES, NAME OF SECONARY INSURANCE COMPANY: \_\_\_\_\_  
POLICY/ID NUMBER: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_  
SUBSCRIBER NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
RELATIONSHIP TO SUBSCRIBER: \_\_\_\_\_

**MOTOR VEHICLE/ WORKER'S COMPENSATION INFORMATION**

MVA OR WC INSURANCE COMPANY: \_\_\_\_\_  
CLAIM NUMBER: \_\_\_\_\_ DATE OF INJURY: \_\_\_\_\_  
ADJUSTOR'S NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_  
STREET ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

## **MEDICAL HISTORY INFORMATION**

Please provide our physical therapists with as much personal medical information as possible. There is space provided at the bottom of this form for any additional information that you feel may be pertinent to your case.

Please circle **Y** for yes and **N** for no.

High Blood Pressure	Y or N
Heart Disease (If yes, please explain below)	Y or N
Pregnant	Y or N
Pacemaker	Y or N
Cancer (If yes, please specify type of cancer below)	Y or N
Heart Irregularities (If yes, please describe below)	Y or N
Diabetes (If yes, please specify type below)	Y or N
HIV/ AIDS	Y or N
Arthritis (If yes, please specify type below)	Y or N
Allergies (If yes, please note below)	Y or N
Lung/ Respiratory Condition, including Asthma	Y or N
Gastro-Intestinal problems	Y or N
Osteoporosis	Y or N
Prior Neck and/or Back condition (If yes, please describe below)	Y or N
Prior fractures (If yes, please describe below)	Y or N
Prior ligament sprain/strain (If yes, please describe below)	Y or N

At this time are you taking any medication? Y or N. If yes, please list below.

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At this time, do you have any precautions/limitations defined by you or your physician concerning exercise? Y or N. If yes, please list below.

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Currently, is there any other medical ailment or condition requiring treatment besides your injury/accident that you are here for today?

Y or N. If yes, please list below.

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Please list below any conditions that may have required surgery in the past.

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Please list below any other medical information that you would like your therapist to have knowledge about.

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## CURRENT CONDITION INFORMATION

Briefly describe the current condition in which you are seeking care.

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When was your most recent doctor visit? \_\_\_\_\_ When is your next doctor visit? \_\_\_\_\_

Have you had any previous treatment for this condition? If yes please check all appropriate boxes.

- |   |  |  |                                      |
|---|--|--|--------------------------------------|
| <input type="checkbox"/> Physical therapy | <input type="checkbox"/> Occupational therapy      | <input type="checkbox"/> Home Care Services (i.e. VNA)   | <input type="checkbox"/> Surgery     |
| <input type="checkbox"/> Medication       | <input type="checkbox"/> Chiropractor              | <input type="checkbox"/> Orthotics, Prosthetics, Bracing | <input type="checkbox"/> Acupuncture |
| <input type="checkbox"/> Massage          | <input type="checkbox"/> other, please list: _____ |  |                                      |

How would describe any pain you are experiencing? Please check all appropriate boxes.

- |                                   |                                   |                                      |                                  |                                      |                                   |                                       |                                     |
|-----------------------------------|-----------------------------------|--------------------------------------|----------------------------------|--------------------------------------|-----------------------------------|---------------------------------------|-------------------------------------|
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Nagging  | <input type="checkbox"/> Intolerable | <input type="checkbox"/> Diffuse | <input type="checkbox"/> Sharp       | <input type="checkbox"/> Shooting | <input type="checkbox"/> Burning      | <input type="checkbox"/> Aching     |
| <input type="checkbox"/> Numb     | <input type="checkbox"/> Tingling | <input type="checkbox"/> Dull        | <input type="checkbox"/> Deep    | <input type="checkbox"/> Superficial | <input type="checkbox"/> Constant | <input type="checkbox"/> Intermittent | <input type="checkbox"/> Occasional |

What are your goals for Physical Therapy?

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What activities are you having difficulty with? (example: driving, walking, sitting, lifting, working)

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What makes the injury worse?

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What makes the injury better?

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Please check the following boxes if you are experiencing any of the following.

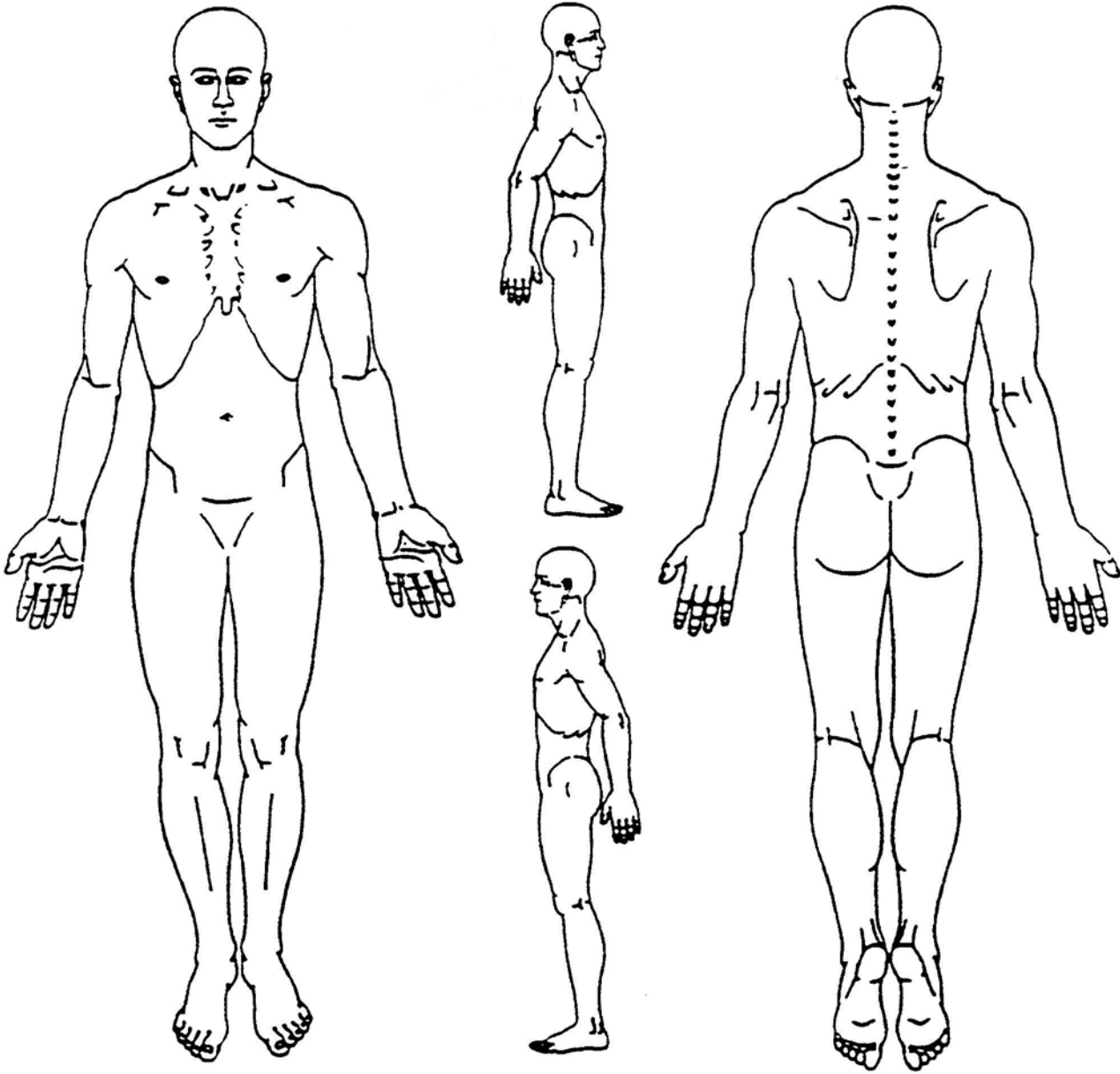
- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Unexplained weight loss          | <input type="checkbox"/> Persistent pain at night       | <input type="checkbox"/> Constant pain                       |
| <input type="checkbox"/> Unusual lumps/growths            | <input type="checkbox"/> Unwarranted fatigue            | <input type="checkbox"/> Shortness of breath                 |
| <input type="checkbox"/> Dizziness                        | <input type="checkbox"/> Pain or heaviness in the chest | <input type="checkbox"/> Pulsating pain                      |
| <input type="checkbox"/> Constant/Severe pain in the calf | <input type="checkbox"/> Swelling with unknown cause    | <input type="checkbox"/> Abdominal pain                      |
| <input type="checkbox"/> Frequent heart burn              | <input type="checkbox"/> Frequent nausea or vomiting    | <input type="checkbox"/> Bladder/bowel changes               |
| <input type="checkbox"/> Menstrual cycle irregularities   | <input type="checkbox"/> Fever or night sweats          | <input type="checkbox"/> Recent severe emotional disturbance |
| <input type="checkbox"/> Swelling/redness without cause   | <input type="checkbox"/> Pregnancy                      | <input type="checkbox"/> Changes in hearing                  |
| <input type="checkbox"/> Severe headaches without cause   | <input type="checkbox"/> Changes in vision              | <input type="checkbox"/> Balance or coordination problems    |
| <input type="checkbox"/> Recent fall                      | <input type="checkbox"/> Faints spells                  | <input type="checkbox"/> Sudden weakness.                    |

Have you had any diagnostic imaging for this condition? (ie X-ray, MRI, ect...) If yes, please describe any known results.

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Please mark on the diagram below where you are experiencing any symptoms related to your injury. (i.e. pain, numbness, tingling)



Using a 0-10 scale to rate your pain, with '0' equal to no pain and '10' equal to the most pain imaginable, answer the following questions.

In the past 48 hours, how would you rate your pain at worst? \_\_\_\_\_/10

In the past 48 hours, how would you rate your pain at best? \_\_\_\_\_/10

**INSURANCE ASSIGNMENT AND RELEASE (NON-MEDICARE PATIENTS)**

I hereby authorize the release of payment from my insurance carrier to Beantown Physio, Inc. I understand that it is my responsibility to know the terms and conditions of my insurance benefit. I assume responsibility for all charges of services rendered that are not covered under my insurance plan, including, but not limited to, treatments received without a valid referral and/or beyond an authorized time period. I am aware that Beantown Physio, Inc. offers a self-pay rate of \$80/evaluation and \$60/follow-up for any visits that I am not authorized for under my insurance carrier. I understand that it is my responsibility to inform the office, as well as my therapist, if my injury is related to a motor vehicle accident or worker's compensation.

Please sign below to indicate you have read and understand the above disclaimer.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

For any questions regarding your physical therapy insurance benefit refer to your insurance plan booklet or call the Member Services phone number located on your insurance card.

**INSURANCE ASSIGNMENT AND RELEASE (MEDICARE PATIENTS ONLY)**

I hereby authorize the release of payment from my insurance carrier(s) to Beantown Physio, Inc. I understand that it is my responsibility to know the terms and conditions of my insurance benefit. Effective January 1, 2006, Medicare has implemented an annual financial limit of \$1810.00 to the amount of physical and speech therapy services combined an individual can have. If you reach this maximum, our office will charge you the Medicare discounted rate of \$40.00 per visit. Medicare has also implemented an exceptions process to this ruling, which allows for automatic and manual exceptions. You will be notified by our office if your injury and/or illness will be considered an automatic or manual exception after your initial evaluation and once your information is processed by our billing department, usually within one or two business days. I also understand I must inform the office, as well as my therapist, if my injury is related to a motor vehicle accident or worker's compensation.

Please sign below to indicate you have read and understand the above disclaimer.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

For any questions regarding your physical therapy insurance benefit contact Medicare directly.

**\*HOME HEALTH WAIVER\***

**I understand that it is my responsibility to inform the office, as well as my therapist, if I am currently receiving home health care. If services are denied by my insurance carrier for the reason of having home health care, I understand that I will be responsible for all outstanding bills.**

Please sign below to indicate you have read and understand the above disclaimer.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTICE OF CANCELLATION/ NO-SHOW POLICY**

Our office reserves the right to assess a \$20 fee to patients who do not formally cancel their scheduled appointment with at least 24-hour notice prior to the appointment. In the event of a snow or ice storm, this policy will not be in effect.

A courtesy no-show/cancellation will be granted to each and every patient. All absentees without at least 24-hour prior notification, after this courtesy, will be charged the above rate. Thank you for your understanding.

Please sign below to indicate you have read and understand the above disclaimer.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Our time with you is valuable, though, if you cannot make the appointment we appreciate the notice ahead of time so that your time slot may be filled with another deserving patient.

### **IONTOPHORESIS**

I understand that if my referring doctor recommends that I receive Iontophoresis treatment, I will be charged **\$10.00 for each pad used in each visit** to cover the expense(s) of the Iontophoresis pads. Iontophoresis is a process of delivering a medication via electrical stimulation. Insurance companies do not cover the extra cost of the pads. I understand that this charge is my personal responsibility and it is an additional charge to my copayment. Your physician will prescribe this type of treatment on your physical therapy prescription/order. The medication for Iontophoresis will need to be purchased separately from a pharmacy and brought in to our office during your treatment visit.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Please refer to your prescription from your doctor to see if he/she recommends that you receive Iontophoresis. For further inquiry ask your therapist.

### **TEACHING FACILITY ACKNOWLEDGEMENT**

Beantown Physio, Inc is proud to be a clinical teaching institution for the following colleges: Duke University, Northeastern University, and Boston University. A licensed physical therapist will be supervising and monitoring your program, though a qualified physical therapy student will be assisting with your treatment. Students are an integral part to our success of delivering a high quality product.

I understand and accept that Beantown Physio, Inc. is a clinical teaching facility and qualified physical therapy students will be involved in the process of my treatment.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

### **PRIVACY PRACTICES ACKNOWLEDGEMENT**

I have received the Notice of Privacy Practices and have been given an opportunity to review it.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Continue to the next two pages to review our Notice of Privacy Practices.

## NOTICE OF PRIVACY PRACTICES

# We Care About Your Privacy

### 1. Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties regarding the use and disclosure of medical information.

### 2. Our Legal Duty

*Law Requires Us to:*

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

*We Have the Right to:*

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practice and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

*Notice of Change to Privacy Practices:*

1. Before we make important change in our privacy practices, we will change this notice and make the new notice available upon request.

### 3. Use and Disclosure of Your Medical Information

This is how we use and disclose medical information. Note: We will not use or disclose your medical information in any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

*For Treatment:*

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or the other people who are taking care of you. We may also share medical information about you to your new health care providers to assist them in treating you.

*For Payment:*

We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

*For Health Care Operations:*

We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses,

and credentials we need to serve you.

*Additional Uses and Disclosures:*

In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes:

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facilities' directories: your name, your location in our facility; your condition described in general terms.

Notification: Medical information to notify or help notify: a family member, your personal representative; another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray, or medical information for you.

Disaster Relief: Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising: We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you with a description of how you may choose not to receive future fundraising communications.

Research in Limited Conditions: We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner:

We may share the medical information about a person who has died with a coroner, medical examiner, or funeral director to help them carry out their duties.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel or veterans, for national security and intelligence activities, for protective services for the President and others, for medically suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

## NOTICE OF PRIVACY PRACTICES

# We Care About Your Privacy

**Court Orders and Judicial and Administrative Proceedings:** We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

**Public Health Activities:** As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

**Victims of Abuse, Neglect, or Domestic Violence:** We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

**Workers Compensation:** We may disclose medical information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

**Health Oversight Activities:** We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other similar programs.

## 4. Your Individual Rights

*You Have a Right to:*

1. Look at or get copies of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format your request unless it is not practical for us to do so. You must make your request in writing. You may ask the receptionist for the form needed to request access. There may be charges for copying and for postage if you want the copies mailed to you. Ask the receptionist about our fee structure

2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations, and other special exceptions.
3. Request that we place additional restrictions on our use or disclose of our medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to our Privacy Officer.
5. Request that we change your medical information. We may deny your request if we did not create the information that you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of the information.
6. If you wish to receive a paper copy of this privacy notice, then you have the right to obtain a paper copy by making a request in writing to our Privacy Officer.

## Questions and Complaints

If you have any questions about this notice, please ask the receptionist for help or ask to speak to our Privacy Officer.

If you think that we may have violated your privacy rights, contact the person named above. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

\* These privacy practices are currently in effect and will remain in effect until further notice.