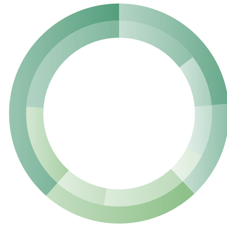

Welcome! Please fill out as much information as possible. If you have any questions or need any assistance please ask the receptionist. Thank you! **(AUTO ACCIDENT)**

Confidential Patient Information

Name(First, Middle, Last):	What do you prefer to be called?	Date
Street Address:	City/State	Zip Code
Home Phone: ( )	Work Phone ( )	Cell Phone/Pager ( )
Email Address:	Date of Birth	Current Age / Sex ☐ M ☐ F
Social Security #:		

Health Insurance Information:

Name or Insurance Company Phone #: ( )	Billing Address	Policy # and Subscriber
Name of Insured/DOB	Relationship to insured ☐ Self ☐ Spouse ☐ Child	Insured's Employer

Auto Insurance Information

Name or Insurance Company Phone #: ( )	Billing Address	Policy # and Subscriber
Name of Insured	Claim # Date of Injury:__/__/__	Claims Adjuster Phone #: ( )

Attorney Information

Name of Attorney	Street Address, City, State and Zip Code	Phone # Fax #

How were you referred to us?

☐ Patient Name:	☐ Physician Name	☐ Other

Primary Care Physician name: **Phone #: ( )**

Work Status: ☐ Employed ☐ Retired ☐ Disabled ☐ Full-time Student ☐ Part-time Student

Employer Phone #: ( )	Occupation and Job Responsibilities	
Employer Address	City/State	Zip Code

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed Spouse's Name_____________________________

Primary Language Spoken________________________________ **Hand Dominance**: ☐ Left ☐ Right ☐ Ambidextrous ☐ N/A

CONSENT OF TREATMENT OF A MINOR

I hereby authorize Jon Dooley, MSPT and whomever he may so designate as his assistant, to administer physical therapy care as he deems necessary to my son/daughter, ____, dated ___________________, 20______ at Greendale Physical Therapy.

Signature: **Witnessed**:

IN CASE OF EMERGENCY

Who should we contact?	Relation
Home Phone: Work Phone: Cell Phone:	

Accident Information

Date of Accident?	Was the accident reported? ☐ Yes ☐ No When?
Where did the accident occur? Street/Town etc.	
Details of the accident	
Please list the symptoms you felt immediately after the accident?	
Please describe the pain and its location.	
What is the intensity of your symptoms? ☐ Slight ☐ Moderate ☐ Severe ☐ Emergency	
How often do you experience these symptoms? ☐ Constant ☐ Frequent (75% of day) ☐ Often (50%) ☐ Seldom (25%) ☐ Rarely (less than 25%)	
What makes your symptoms worse?	
What makes your symptoms better?	
Is the condition interfering with your: ☐ Sleep ☐ Work ☐ Daily Routine If so, Explain:	
Where you wearing a seat belt? ☐ Yes ☐ No	Where were you located in the vehicle? ☐ Driver ☐ Front seat passenger ☐ Other_________________________
Where were you taken after the accident?	Where you taken to the Hospital by ☐ Ambulance ☐ Private Vehicle ☐ Other___________________________
Where X-ray taken? ☐ Yes ☐ No	MRI? ☐ Yes ☐ No Catscan? ☐ Yes No
Give the dates you missed work as a result of the accident. Additional Information:	
Have you sought any other treatment for this condition? ☐ Yes ☐ No If so, where and by whom?	
Have you been treated by a physical therapist before? ☐ Yes No If so, where and by whom?	

Do you regularly exercise or work out? ☐ Yes ☐ No If so, how often?

Health History

Are you taking any of the following medications:

☐ Nerve pills ☐ Non prescription pain killers ☐ Muscle relaxes ☐ Stimulants
☐ Blood thinners ☐ Tranquilizers ☐ Insulin ☐ Other______________________________

Please list any previous surgeries, serious traumas, or serious accidents, include dates if known.

1.____ Date__________________________________
2.____ Date__________________________________
3.____ Date__________________________________

Do you have, or have you ever had, any of the following diseases or conditions? Check all that apply:

☐ No Past Medical History	☐ Emphysema/Glaucoma	☐ Multiple Sclerosis	☐ Alcohol/Drug Abuse
☐ Fainting/Seizures/Epilepsy	☐ Muscular Dystrophy	☐ Anemia	☐ Frequent Neck Pain
☐ Osteoporosis	☐ Arthritis	☐ Heart Surgery/Pacemaker	☐ Frequent Headaches
☐ Blood Disorder	☐ Hepatitis	☐ Shingles	☐ Cancer
☐ High/Low Blood Pressure	☐ Sinus Problems	☐ Chemotherapy	☐ HIV+/AIDS
☐ Tuberculosis	☐ Circulation Problems	☐ Kidney Problems	☐ Ulcers/Colitis
☐ Currently Pregnant	☐ Liver Disease	☐ Diabetes	☐ Lower Back Problems
☐ Difficulty Breathing	☐ Mitral Valve Prolapse	☐ Other____________________	☐ Other_______________

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform the office of any changes to the information I have provided.

Signature:____ Date________________________

FINANCIAL POLICY & INSURANCE VERIFICATION

Thank you for choosing our clinic and therapy staff to serve your Physical Therapy needs. We will make every effort to help you recover quickly. Please take a moment to read the following information about your plan's physical therapy benefit.
Your insurance benefits were verified on ____/_____/_____. We spoke to _______________________________, the insurance representative, who informed us that approved charges would be considered at _______% after you have satisfied a $____________ deductible at which time $____________ has been met. Your co-payment/co-insurance for each date of service is $___________.

******PLEASE NOTE THAT THIS IS NOT A GUARENTEE OF BENEFITS OR PAYMENT******
It is your responsibility to know your benefits or to call and verify them yourself. We cannot guarantee that your insurance company gives us the correct information.

It is our policy to collect your $___________ co-payment, co-insurance, and or deductible at the beginning of each visit when you check in at the front desk.
After insurance claims have been processed, you will be responsible for any balances due on approved charges, or non-covered services. At any time if your Insurance decides these services are not covered or considered maintenance care under your plan, and/or they take their payments back, any **past / previous** dates of service to any future dates of service you will be responsible for payment in full.
I authorize my insurance company to make payment for my services directly to the provider.

_______________________________________ _______________________
Patient's Signature Date

____
Patient's Name

Copy to patient _________ Staff initials _________

GREENDALE PHYSICAL THERAPY

7 Neponset Street
P.O. Box 60081
Worcester, MA 01606
508-459-5000

SPECIFIC AND IRREVOCABLE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

1. You are authorized to release any information you deem appropriate concerning my health condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred at Greendale Physical Therapy by me.

2. I authorize and assign the direct payment to you of any sum I now, or hereafter, owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

3. I give assignment and lien against any claims against a third party whose negligence may have caused the patient's injury, up to the amount of the bill for treatment.

4. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data below) and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company (or companies) contractually obligated you will refrain from attempts and efforts to collect the amount owed directly from me. I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.

5. I waiver the Statute of Limitations regarding my doctor's right to recover.

Date:___________ Signed:__________________________

Date:___________ Witnessed:__________________________

Date of Injury:________________ Patient Name:____

Insured Name (If different from patient):____

Name of Insurance Co:____

Claim No:____________________________ Claims Adjuster:___________________________