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.	
On a scale from 0-10 (0=no pain / 10= worst possible pain): What is your current pain?_____/10 What is your pain at its worst? _____/10 What is your pain at its best? _____/10	
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 relaxers ☐ 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________________________

PATIENT NAME:	
DATE OF BIRTH:	
CASE:	

Greendale Physical Therapy, LLC - Notice of Privacy Practices for Protected Health Information

In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (**HIPAA**), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, as it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, please contact the Greendale Physical Therapy HIPAA compliance officer, Julianne Gonzalez at (508) 853-4590.

Uses and Disclosures
Here are some examples of how we might have to use or disclose your health care information:

1. Your Physical Therapist or a staff member may have to disclose your health information including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis or treatment of your health condition.
2. Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are potentially responsible for the payment of your services.
3. Your Physical Therapist and members of this staff may need to use your health information, examination and treatment records for quality control purposes to run our practice efficiently and effectively.
4. Your Physical Therapist and members of the practice staff may need to use your name, address, phone number, email address and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that might be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives or other health related information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

Your Right to Receive Confidential Communication
We normally provide information about your health to you in person at the time you receive services. We may also mail or email you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide at a place other than your home or if you would like the information in a different form. To help us respond to your needs, please make any request in writing.

Your Right to Inspect and Copy
You have the right to inspect and request a copy your health information for seven years from the date the record was created or as long as the information remains in our files. We require requests for inspection or copies of your health information to be in writing. Appropriate fees may apply.

Your Right to Amend
You have the right to request that we amend your health information for seven years from the date the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing with a reason to support the change you are requesting us to make.

Re-Disclosure
Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

Your Right to Revoke Your Authorization
You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will be able to honor your revocation request.

1. If we have already released your health information before we receive your request to revoke your authorization. 164.508(b) (5) (i)
2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. If you wish to revoke your authorization

please write to us at our office address, in care of our Billing Department.

Other Permitted Uses and Disclosures Without Consent or Authorization

Under Federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

1. If we are providing health care services to you based on the orders of another health care provider.
2. If we provide health care services to you as an inmate.
3. If we provide health care services to you in an emergency.
4. If we are required by law to treat you and were unable to obtain your consent after attempting to do so.
5. If there are substantial barriers which prevent communication with you, but in our professional judgment we believe that you intend for us to provide care.

Other than the circumstances described in the examples above and in the Uses and Disclosures section of this notice, any other use or disclosure of your health information will only be made with your written authorization.

Your Right to Receive an Accounting of Disclosures Made of Your Records

You have the right to request an accounting of the disclosures we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except those disclosures:

1. Required for treatment, to obtain payment for services or to run our practice.
2. Made to you or those involved in your care.
3. Necessary to maintain a directory of the individuals in our facility.
4. For national security or intelligence purposes, as required by law.
5. That were made prior to the effective date of the HIPAA privacy law.

We will provide the first accounting within any twelve month period without charge. There is a fee for any additional requests during that next twelve months. When making a request we will tell you the amount of the fee and you may withdraw or modify your request at that time.

Your Rights to Limit Uses or Disclosures

If there are health care providers, hospitals, employers, insurers or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restriction, you may drop your request or you are free to seek care from another health care provider.

Our Privacy Pledge

We have and always will respect your privacy. Other than the uses and disclosures described within this notice, we will not sell or provide any of your health information to any outside marketing organizations.

Our Duties

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information. We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement we will notify you in writing when you come for treatment or by mail. If we make a change in our privacy terms the change will apply for all of your health information in our files.

Your Right to Complain

You may complain to us or to the Secretary for Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint at, written comments should be addressed to Julianne Gonzalez, 280 Boston Turnpike Shrewsbury, MA 01545

To Contact Us

If you would like further information regarding our privacy policies and practices, please contact our HIPAA officer, Julianne Gonzalez at (508) 853-4590.

Your Signature

Your signature acknowledges that you have received a copy of Greendale Physical Therapy's Notice of Privacy Practices and Protected Health Information. *This notice is effective as of April 14, 2003 or the date you first signed the acknowledgement of receipt of this notice. This notice expires seven years after the date upon which your record was created, which is seven years after the last date of service.*

PATIENT SIGNATURE	TODAY'S DATE

PATIENT NAME:	
DATE OF BIRTH:	
CASE:	

Greendale Physical Therapy, LLC – General Policies and Consent

Consent to Treat

I consent and authorize for myself or my child to be evaluated and treated by Greendale Physical Therapy, LLC, through its appropriate personnel. I understand that no guarantee has been made to me about the outcome of my care. I understand that Greendale Physical Therapy works with academic institutions to provide healthcare students training and learning opportunities and that they may be involved in my care, under the supervision of appropriate personnel. I understand I have the right to refuse the involvement of healthcare students in my care.

Consent to Bill Insurance

I consent and authorize Greendale Physical Therapy, LLC to bill my insurance on my behalf and to authorize my insurance company and or attorney make payments directly to Greendale Physical Therapy, LLC for services rendered.

Consent for Patients that are Minors

A signature of a parent a legal custodian of a minor is required on all paperwork to indicate the parent or legal guardian agrees to each form on behalf of the minor.

Supervision of Minors Policy

A minor is considered any patient under the age of 18. Any patient under the age of 12 needs a parent or guardian on site during treatment; the parent or guardian may choose to stay in the waiting room. Patients between the ages of 12-17 may be seen without a parent or guardian on site based on the therapist's judgement. This decision may be based on the diagnosis as well as the maturity of the patient. If a parent or guardian leaves the premises, we must have a phone number on file where they can be reached in an emergency. A parent or guardian must be on site to review this policy with the therapist before, during, or after initial evaluation.

Assisted Soft Tissue Mobilization (ASTM)/Scraping/Graston

Assisted Soft Tissue Mobilization, also known as scraping or Graston, is an instrument assisted variation of traditional cross fiber or transverse friction massage. The ASTM instruments consist of stainless steel tools of various sizes and contours. ASTM is a form of treatment used to "break up" or "soften" scar tissue, thus allowing for the return of normal function in the area being treated. ASTM *may* produce the following: local discomfort during the treatment, reddening of the skin, superficial tissue bruising, post treatment soreness. Assisted Soft Tissue Mobilization is designed to minimize discomfort; however the above reactions *are* normal, and in some instances they *are* unavoidable. Assisted Soft Tissue Mobilization is not appropriate for every course of treatment. Should my therapist determine it is appropriate for me, I agree that I have been made aware of the potential effects. I understand that I may refuse ASTM.

Fever-Free Policy

Patients, visitors, staff and vendors must be fever free, without medication, for 24 hours before entering the clinic.

Covid-19 Policies

Greendale PT is committed to upholding all Massachusetts requirements regarding Covid-19. Information and polices will change as updated by the Commonwealth. Policies are posted inside the clinics and on our website, www.GreendalePT.com.

Cellular Phone/Digital Device Policy

Patient are asked to conduct phone calls away from the treatment area so as not to disrupt care of other patients. We kindly ask that notifications are set to vibrate. No pictures are allowed to be taken inside Greendale Physical Therapy to respect the privacy of all our patients.

Your Signature

Your signature acknowledges that you have received and agree to Greendale Physical Therapy's General Policies for yourself or for your child, if the patient is a minor.

______________________________ PATIENT SIGNATURE

______________________________ TODAY'S DATE

PATIENT NAME:	
DATE OF BIRTH:	
CASE:	

Greendale Physical Therapy, LLC – Patient Attendance Policy

During your initial evaluation, you and your therapist will create a treatment schedule specific to your physical therapy needs. Treatment plans are typically composed of 2-3 appointments per week. A consistent treatment schedule is vital to the success in your physical therapy progress. Failing to abide by the schedule set by you and your therapist could result in failure to achieve desired outcomes.

Cancelling/Rescheduling

We kindly request that you notify us no later than 24-hours in business days prior to your scheduled appointment time should you need to cancel or reschedule. This will allow us to offer this appointment slot to other patients. For appointments that fall on a Monday or the day after a holiday, notification must come the business day before the appointment. For example, a 3:00 pm Monday appointment must be cancelled by 3:00 pm on Friday to be considered 24-hours in business. Appointments cancelled or rescheduled with less than 24-hours in business days' notice, will be considered a late cancellation and **a $25.00 fee** will be assessed and an invoice will be mailed to you. Greendale understand emergencies happen and if the reason for a late cancellation was an illness or emergency, Greendale will only be able to waive one attendance fee per case.

Late Arrivals

If you arrive up to 15 minutes late for an appointment, it will be up to the therapist to determine if they are still able to see you based on their schedule. For any appointment in which you arrive more than 15 minutes past the scheduled time, you will be required to reschedule the appointment. This will be determined on a case-by-case basis and is at the therapist's discretion. In the event you arrive too late to be seen, a **$50.00 fee** will be assessed and an invoice will be mailed to you.

No Call/No Show

Any appointment in which you fail to arrive for without prior notification will be considered a no show and a **$50.00 fee** will be assessed and an invoice will be mailed to you. If you no show two appointments in a row, all future visits will be cancelled. We will call you to notify you that we have cancelled the appointments. You may schedule again, once all attendance fees are paid in-full.

Attendance Fees

Any fees assessed for non-compliance of Greendale Physical Therapy's Attendance Policy must be paid by cash or credit card prior to your next visit. These fees are not reimbursable by insurance companies and are the sole responsibility of the patient.

Attendance and Insurance Authorizations

For patients that are treating through an insurance company that requires prior-authorization for services, please note that:

- Greendale will book visits that are pending receipt of authorization. If authorization has not arrived 24 business hours prior to the scheduled visit, our staff will call you to give you the option to cancel the appointment with no attendance fee - or - keep the appointment and pay the $95.00/visit self-pay rate.. If you chose to keep the appointment, Greendale will still attempt to obtain authorization and bill your health insurance. If your health insurance covers the visit, you will be reimbursed the $95.00 after your case has discharged and paid in full.
- Insurance companies attached a date range and visit count number to their authorizations. Greendale Physical Therapy attempts to schedule out a patient's plan of care in accordance to the authorization requirements of your insurance plan. Missing a scheduled appointment can affect the authorization schedule and result in a gap in care.
- In certain situations such as workers' compensation cases, Greendale Physical Therapy is required to report treatment compliance, which includes keeping scheduled appointments, to the utilization reviewer. Non-compliance with attendance often results in future coverage of care being denied by your insurance company.

Non-Compliance of Attendance Policies

Greendale Physical Therapy reserves the right to discharge any patient with 3 or more Attendance Policy violations. As an alternative, Greendale may tell a patient they can only book same-day appointments.

Your Signature

Your signature acknowledges that you have received and agree to Greendale Physical Therapy's Attendance Policy.

______________________________	______________________________
PATIENT SIGNATURE	TODAY'S DATE

PATIENT NAME:	
DATE OF BIRTH:	
CASE:	

Greendale Physical Therapy, LLC – Financial Policy

Self-Pay

Our self-pay rate is $95.00 per visit and is due at the time of service. Greendale does not bill for self-pay visits. You may pre-pay self-pay visits and any unused visits will be refunded after the case is discharged. We are able to determine a flat per visit rate for self-pay patients since they are not subject to using Common Procedural Terminology or CPT codes that insurance companies require to be billed and are contracted at various rates. Self-pay visits will be documented as normal, but as no CPT codes used, Greendale is not able to retro-bill an insurance company for self-pay visits. If you are a self-pay patient and wish to begin using an insurance company or third party payer, your self-pay case will be discharged and a new Initial Evaluation will be required through your new payer. Self-pay patients are still subject to Massachusetts laws that require an evaluation be performed every 30 days.

Health Insurance

Greendale Physical Therapy will happily bill a health insurance company on your behalf. Greendale is in contract with many insurance companies. Prior to your first visit, Greendale will contact your insurance company to confirm that you have active coverage and determine if Greendale PT is considered "in network" or "out of network". If Greendale PT is considered "out of network" you may have "out of network" benefits. Our staff will inquire about what your out-patient physical therapy benefits are.

We will inform you of the benefit information we receive from your insurance company in regards to treatment visit limits, script/referral requirements, authorization requirements and your financial responsibility**. It is your responsibility to know your benefits. We strongly encourage you to also verify your benefits with your insurance company. Greendale Physical Therapy cannot guarantee that your insurance company provided us the correct information. All charges will be processed as determined by your insurance company even if they differ from the benefits information your insurance company provided Greendale PT.** Please note that Greendale PT will bill your services under the supervising Physical Therapist when you are treated by a Physical Therapist Assistant.

For patients with a benefit that only involves a copay, we will be able to tell you how much each visit will cost and the copay is due at the time of service. For patients that are treating under a deductible and/or co-insurance, Greendale is not able to provide a definite amount each visit will cost as it will depend on which CPT codes your therapist determines is appropriate treatment at each visit. Greendale will ask for a payment at each visit to go towards your financial responsibility. While treatment is active, Greendale will periodically or at your request, reconcile your account and send you a statement and invoice. If your at-the-time-of-service payments exceeds your financial responsibility as determined by your insurance company, a refund will be processed after your case is discharged and all date of service have been processed by your insurance company. Please note that it often takes 30 days from the date of service for an insurance company to process a claim.

Patients must provide all insurance information during registration, including secondary and tertiary insurance information if applicable. If you have more than one insurance, Coordination of Benefits will be determined by your insurance companies. It is the patient's responsibility to immediately notify Greendale of any changes to their insurance. Greendale will not retro bill an insurance company, but will supply the patient with the documentation necessary to attempt to receive reimbursement past dates of service.

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 plan 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.

Motor Vehicle Accident (MVA)

Patients treating as a result of a motor vehicle accident will be processed according to Massachusetts laws or the laws of the state in which the MVA occurred. In Massachusetts, providers are to first bill the patient's MVA insurance, regardless of who was at fault for the accident. Payment for this will come from the Personal Injury Protection or PIP portion of the insurance. PIP is limited to either $2,000 or $8,000 depending on the policy type. A PIP application must be on file with your MVA insurance company prior to your first visit. Once PIP exhausts, providers must bill the patient's health insurance with a copy of the PIP exhaust letter attached.

Because Greendale is unable to determine if or when the PIP has exhausted at the time of registration, Greendale requires patients treating under an MVA to have active, in-network health insurance in addition to MVA insurance. If the patient does not have active, in-network health insurance, it is Greendale's policy to collect $95.00 at the time of service for each visit. Greendale will bill the MVA insurance and if the PIP insurance has not exhausted and covers the visit, Greendale will refund the patient the $95.00.

If you have an attorney involved with your MVA, you must complete an Authorization for Disclosure of Protected Health Information form allowing us to speak to your attorney, or HIPAA laws will prevent us from communicating with the attorney. If your attorney files an Assignment of Benefits with your PIP carrier, you are still responsible for payment within standard billing expectations.

Worker's Compensation (WC)

Patients treating as a result of an employment injury will require case adjuster approval for their initial evaluation. After the initial evaluation, documentation of the visit will be sent to the utilization review department to obtain authorization for future visits. WC Authorization turnaround is typically 5 business days. Greendale will not collect any health insurance information at registration or ask for payment at the time of service. Note: Some treatment options are not covered by WC insurance and patients will be given the option of paying out-of-pocket for if they wish to receive them. Examples are dry-needling and iontophoresis.

Forms of Payment/Returned Checks

Greendale accepts cash, check, Visa, MasterCard and Discover. Greendale does not accept American Express. Returned checks will assessed a $25.00 fee and future payment may not be made via check.

Missed Payments

If you arrive for a visit and are unable to make the payment due at the time of service, Greendale will still allow you to be seen. You must make the missed payment before or at your next visit. If you arrive for a second visit without payment, we will be unable to see you.

Billing Records and Questions

The billing department for all Greendale Physical Therapy clinics is located in our Administrative offices. Local clinic staff do not have access to the billing software and are not able to access complete financial records. Billing questions should be directed to the billing department via phone at (508) 853-4590, option 2 or via email at Billing@GreendalePT.com. Questions regarding how your insurance company processed a claim should be directed to your insurance company.

Invoices and Terms

After all claims have been processed by all involved insurance plans, an invoice for any remaining patient responsibility will be mailed or emailed to you. Payment is due within thirty (30) days from the date responsibility was assigned, which is often thirty days or more after the date of service. A late fee may be assessed for any balance not paid by the due date. If payment is not received in full or no under a payment plan, unpaid balances will be sent to collections after ninety (90) days.

Payment Plans

If you need more time to make your payments, please contact the billing department to inquire about payment plan options. We want to work with you.

Refunds

If it is determined that a patient is owed a refund, Greendale will mail a refund check to the patient. We are unable to process refunds on credit cards.

Your Signature

Your signature acknowledges that you have received and agree to Greendale Physical Therapy's Financial Policy.

______________________________	______________________________
PATIENT SIGNATURE	TODAY'S DATE