Essex Physical Therapy and Chiropractic
16 Haverhill St Andover, MA

Name:_____ Date of birth:____/____/_____
(last) (first) (M.I.)

Email Address:_____ Marital Status: M D S Other Gender: M F

Address:_____City:_____State:_____Zip:_____

Phone: (home) _____ (cell)_____

Ins Subscriber's full name:_____Ins Subscriber's date of birth _____

Emergency contact:_____ Emergency contact number:_____

Primary Doctor:_____ Referring Doctor:_____

Employer:_____ Have you had PT/Chiropractic care this year: Yes No

Did a family member or friend recommend us to you? Y N

Is your injury/condition a result of a work related incident or motor vehicle accident? Yes No

Medicare Only

Have you had any physical/speech/occupational therapy/ or chiropractic care so far this year? Yes No

If YES, where and when did you have it: _____

Do you have a home health care agency coming to your house? Yes No

If YES, who is the agency and what is the phone number: _____

Do you have secondary insurance? Yes No If yes: _____

Workers' Compensation and Motor Vehicle Accident Only

Ins Co:_____Address:_____City:_____State/Zip_____

Claim #:_____Phone #:_____

Date of Injury/accident:_____Employer:_____Adjuster name:_____

Adjuster ph #:_____Attorney:_____Attorney ph #:_____

I,_____hereby authorize and instruct my insurance carrier to pay Essex Physical Therapy and Chiropractic, directly for any medical services performed. Additionally, I understand I am financially responsible for payment of all co-pays, deductibles, and balances not covered by Medicare, or my insurance carrier, provided my specific plan does normally pay for the services and/or products rendered to me by the medical providers at this facility. I understand that if I default on my account it may be sent to collections, which will result in an additional fee of 23% of account balance. If I am the legal guardian/representative of the patient named above, I accept responsibility for the above as well. I also authorize the release of any and all medical records to my insurance carrier for the purpose of expediting claim payment.

_____ _____
Insured or Authorized Person's Signature Date

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CONSENT FOR TREATMENT, ASSIGNMENT OF MEDICAL BENEFITS AND PAYMENT RESPONSIBILIY

1. **MEDICAL CONSENT:** The undersigned herby authorizes provider to render to Patient physical therapy, chiropractic care or other related services (collectively referred to as "Services") that Provider, or Patient's treating physician determines may be necessary or advisable. Patient agrees to cooperate with all reasonable requests by Provider in connection with Provider's rendition of Services. The undersigned acknowledges that no guarantees have been made as to the results of assessment and treatment.

I understand that I will be receiving the following treatment modalities at various times throughout my care in this office as prescribed by the doctors/therapist including:

- Joint mobilizations ranging from grade I-IV possibly including grade V manipulation in an attempt to decrease pain, improve ROM and promote proper healing. This may include manual as well as static traction.
- Various forms of electrical stimulation including interferential current therapy, TENS, continuous and pulsed ultrasound and NMES (neuromuscular electrical stimulation). These electrical modalities are used in an attempt to decrease pain and inflammation as well as to increase tissue extensibility, circulation and promote a proper healing environment and strengthen associated muscles. Please notify the doctor if you are pregnant or have any type of metal implant such as a pacemaker.
- Soft tissue massage used to decrease pain, improve range of motion and decrease muscle tightness/spasms.
- Various forms of soft tissue stretching techniques (and other forms of manual medicine) are used to prevent scar tissue formation, decrease muscle tightness and to promote proper biomechanics.
- Therapeutic exercises/stabilization techniques will be used in the office and prescribed as part of a home exercise program to improve strength, range of motion, stability, balance, endurance etc. in an attempt to stabilize the injured areas and to prevent long term disability.

2. **PAYMENT FOR SERVICES:** The undersigned understands that payment is expected at the time of service for all Services. Insurance will be filed for services rendered. Patients with Medicare, Medicaid, and other Managed Care Contracts with whom we have agreements will be honored for all visits. CO-PAYS are expected at the time of service.

3. **MEDICAL RECORDS RELEASE:** The Patient or the guarantor of the account hereby authorizes Provider to release Patient's medical record (including any information furnished to Provider or obtained by Provider in connection with Patient's treatment) to any referring physician, insurance company, health care facility or governmental agency (including the Social Security Administration or any of its intermediaries or carriers) requesting such information. Authorization is also given to release records to insurance carriers for the purpose of payment of claims including worker's compensation claims to both carrier and employer.

4. **MEDICAL INSURANCE BENEFITS:** The undersigned, hereby assigns to Provider all private medical insurance benefits (primary, secondary, and medi-gap providers) or other benefits to which Patient may be entitled for any Services rendered by Provider. The undersigned hereby authorizes and directs Provider to apply and file for all such benefits on behalf of Patient.

5. **MEDICARE AND MEDICAID AUTHORIZATION:** I certify that the information given by me in applying for payment under TITLES XVII AND IXIX of the Social Security Act is correct and I request payment of authorized benefits to be made in my behalf. I authorize Provider to release to Medicare Bureau, Health Care Financing Administration or its intermediaries or its carriers, any information about me needed for Medicare claim, including medical information for the purpose of processing a claim for Medicare benefits. I also authorize the release of medical and related information about my treatment to the utilization and quality control peer review organization responsible for reviewing the medical care furnished to me. I further state under both titles that I do not have any other insurance that is to be filed primary over my Medicare and/ or Medicaid.

6. **FINANCIAL RESPONSIBILITY:** I acknowledge full responsibility for Services rendered and agree to make definite financial arrangements for payment. I understand that the charges made for the Services may not be covered in full by my health insurance and therefore I am solely responsible for payment of all uncovered Services. I further request that payment be made directly to "Provider" according to assignment of benefits. If payment arrangements have not been made or full payment is not received in 60 days for the date of service, your account may be turned over to an attorney or collection agency. I understand that should the account be sent to an attorney or collection agency, I will be responsible for any and all extra costs or fees incurred. I understand there will be a charge of $20 for any bounced checks.

7. **Missed Appointments:** A $20 charge may be applied for any cancelled or missed appointments without 24 hours' notice.

8. **ACKNOWLEDGE OF RECEIPT OF PRIVACE PRACTICE NOTICE:** By signing this form you acknowledge receipt of the Notice of Privacy Practices.

9. **The Patient/Client Rights and Responsibilities Information**: By signing this you acknowledge the notice of the patient rights and responsibilities.

_____ _____

Guarantor/Patient Signature **Date**

_____ _____

If Patient is under 18, Guardian's Signature **Date**

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MEDICAL HISTORY / SUBJECTIVE INFORMATION

Medical History: **(Please check all that apply)**

____ Heart Disease	____ Diabetes	____High Blood Pressure	____Pacemaker
____ Cancer	____ Tuberculosis	____Heart Problems	____ Epilepsy
____ HIV /AIDS	____ Arthritis	____Seizures	___Prostate issues
____ TIA/Stroke	____ Asthma	____Latex Allergy	____ Thyroid Problems
____ Osteoporosis	____ Hepatitis	____Heart Attack	
____ Chest Pain	____ Kidney Problems	_____Pregnant	
____ Metal Implants	____ Dizziness	____Fractures	

Therapist's comments: _____

_____

Have you had surgery for your condition? Y N If yes, please give approximate date:_____

Have you had any injections for your condition? Y N If yes, please give approximate date:_____

Please list any diagnostic tests you have had for this condition: _____

Please list any **medications** that you are taking: _____

What are your current symptoms?_____

How the injury or problem occur?_____

Please rate your pain using a 0 – 10 scale (0 = no pain, 10 = the worst pain you can imagine)

Worst pain since onset:_____ **Best** pain since onset:_____ **Today's** pain:_____

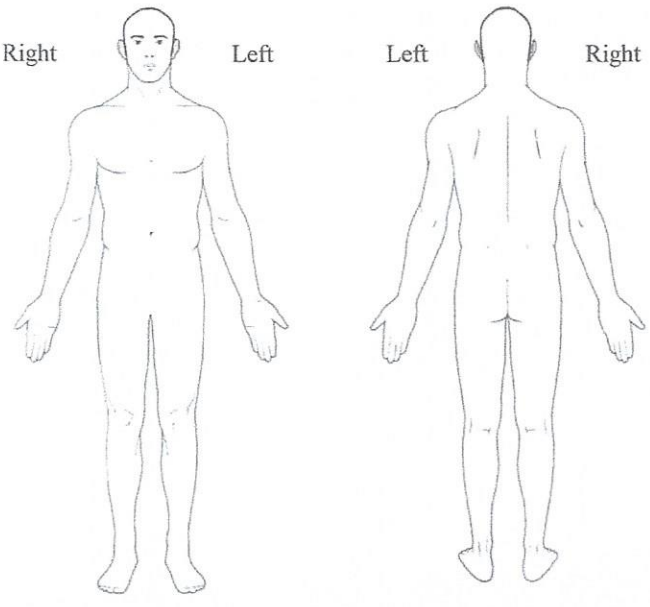
Where is your pain or problem located?_____

Is your pain? Constant Intermittent

What makes your pain / problem **better**?_____ **Worse**?_____

Is there pain present at night? Y N What position helps you to sleep? _____

Please mark the areas where you feel your symptoms on the diagram below:



SYMPTOM FORM

PLEASE CIRCLE ANY OF THE FOLLOWING SYMPTOMS ASSOCIATED WITH YOUR CHIEF COMPLAINT:

- ✓ Fever:
- ✓ Chills:
- ✓ Nausea:
- ✓ Vomiting:
- ✓ Chest Pain:
- ✓ Shortness of Breath/Difficulty Breathing:
- ✓ Loss of Memory / Concentration:
- ✓ Loss of Balance:
- ✓ Difficulty Speaking:
- ✓ Difficulty Swallowing:
- ✓ Stomach Pain:
- ✓ Pain on Urination:
- ✓ Blood in Urine or Stool:
- ✓ Loss of Control of Bowel / Bladder:
- ✓ Increased Pain Following Eating:
- ✓ Pain which wakes you up at night:
- ✓ Pain not relieved with rest:
- ✓ Loss of Appetite:
- ✓ Unexplained Weight Loss:
- ✓ Women Only: Is there any chance you may be pregnant? Yes / No. Date of last cycle?_____.
- ✓ Do you have any metal in your body?
- ✓ Do you have a pace maker?
- ✓ Are you Allergic to latex?

Signature: _____ Date: _____

Pain Chart- Dr's Notes (Filled Out By Doctor)

Name: _____

Age: Ht: Wt: Smoker: Employed FT/PT

PMH:

Onset: _____

Provocative: _____

Palliative: _____

Quality: _____

Side/Radiation: _____