ESSEX PHYSICAL THERAPY AND CHIROPRACTIC

1/1/2017

16 HAVERHILL STREET
ANDOVER, MA 01810
978-470-1499
FAX 978-470-1408

To all of our patients:

Our billing office will be happy to process insurance claims to your health insurance company for reimbursement of your physical therapy / chiropractic care. Please note that all plans are different and although we will do our best to verify your benefits, they are dictated by the insurance company. Our office has contracted rates with each carrier and although we will accept those rates, most plans will have a patient responsibility such as a deductible, co-insurance or fixed copay per visit which is set by your insurance company. Note that you will be held responsible for any balance due. Some plans, such as HMO's will also require an authorization from your primary care physician's office. This is subject to change at any time by your insurance carrier or if you change insurance companies at any time during your care. Thus it is your responsibility to notify our office if your insurance has changed. **We highly recommend that you call your insurance carrier to verify your financial responsibility to this office and to confirm if any referral or authorization is required prior to starting care.**

Thank you for your understanding and cooperation and we look forward to working with you.

Patient signature: ______________________________

Date: ____________________

Sincerely,

ESSEX PHYSICAL THERAPY AND CHIROPRACTIC LLC.

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:

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

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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

Essex Physical Therapy and Chiropractic

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 that all treatments may pose some associated risks including strain/sprain/fractures/burns/injuries/vascular injury among others. Please discuss any concerns with your doctor or therapists.

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. **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.

3. **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.

4. **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.

5. **FINANCIAL RESPONSIBILITY:** I acknowledge full responsibility for services rendered and agree to make definite financial arrangements for payment. The undersigned understands that payment is expected at the time of service. Our office will process your insurance claims for services rendered. However, 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, including any deductibles, co-pays or co-insurance. 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.

   Patients with Medicare, Medicaid, and other Managed Care Contracts with whom we have contracts will be honored. However, please be aware that insurance is subject to change at any time and it is the sole responsibility of the patient to notify this office of any such changes that occur during your treatment and you will be responsible for any balance due. In addition, it is the patients' responsibility to verify that our office participates with your specific insurance plan and if any referral or authorization is required by the plan, it is your responsibility to obtain it prior to your appointment or you may be held responsible for any costs.

   CREDIT CARD ON FILE POLICY: Due to recent changes in health care reimbursement and the trend towards high deductible/co-pay plans, we will be requiring patients to leave a credit card on file with the practice and thus patients will be asked to sign a **Card on File Agreement.** We will be using Worldpay to process all transactions as they provide secure processing of all our credit card transactions. **You will receive prior notification from us before any charges are made to your credit card.**

6. **NO SHOW/CANCELLED APPOINTMENTS:** A $50 charge may be applied for any cancelled or missed appointments without 24 hours' notice.

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

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

X ______________________________ ______________________________

Guarantor/Patient Signature **Date**

X ______________________________ ______________________________

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

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CREDIT CARD ON FILE AGREEMENT/AUTHORIZATION FORM

PATIENTS NAME: ______________________________

CARDHOLDER INFORMATION:

NAME ON CREDIT CARD: ______________________________

BILLING ADDRESS: ______________________________

CREDIT CARD TYPE: PLEASE CIRCLE ONE.

MASTERCARD / VISA/ AMEX / DISCOVER / OTHER

CREDIT CARD NUMBER: ______________________________

EXP DATE: ____________________ **SECURITY ID:** __________

CARDHOLDER SIGNATURE: ______________________________

DATE: ____________________

I AGREE TO KEEP MY CARD INFORMATION ON FILE WITH ESSEX CHIROPRACTIC AND PHYSICAL THERAPY LLC FOR ANY OUTSTANDING DEDUCTIBLE/COPAYS/UNPAID BALANCES OR CHECKS ISSUED TO ME BY MY INSURANCE CO FOR TREATMENT OR SERVICES RENDERED WHILE I WAS A PATIENT AT ESSEX CHIROPRACTIC AND PHYSICAL THERAPY, LLC.

YOU WILL RECEIVE PRIOR NOTIFICATION FROM US PRIOR TO ANY CHARGES MADE TO YOUR CREDIT CARD.

ESSEX PHYSICAL THERAPY AND CHIROPRACTIC LLC.

Essex Physical Therapy and Chiropractic

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:________

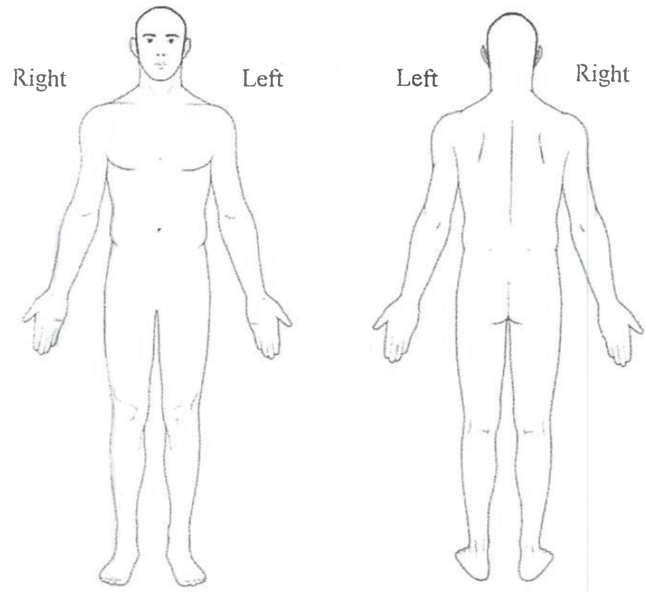
Where is your pain or problem located?______________________________

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: ____________________