BAY STATE
PHYSICAL THERAPY

Worker's Compensation Intake Form

Patient Information:

Name _____ Home Phone _____
Address _____ Work Phone _____
_____ Social Security No. _____
_____ Date of Birth _____
Sex ☐ **Male** ☐ **Female** Height ____' ____" Weight _____ lbs
Occupation _____ Marital Status _____
Employer _____ No of Children _____
EMAIL ADDRESS_____
If minor, name of parent or guardian _____
Nearest relative not living with you _____
Relation _____ Phone _____
Address _____
Attorney _____ Phone _____
How did you hear about Bay State Physical Therapy? ☐ Friend/Former patient_____ ☐ Website
☐ Gym member ☐ Drive by ☐ Walk in ☐ Yellow pages ☐ Moneysaver ☐ Doctor_____

Accident Information:
Date _____ Time _____ AM PM Was it reported? ☐ **YES** ☐ **NO**
Town accident occurred in _____ Street _____
Please explain in detail how the accident occurred _____
_____
Please list symptoms felt immediately after the accident _____
_____
Where were you taken after the accident? _____
If hospital, how were you taken? ☐ **AMBULANCE** ☐ **PRIVATE VEHICLE** ☐ **OTHER**
Were X-Rays done? ☐ **YES** ☐ **NO** An MRI? ☐ **YES** ☐ **NO** CAT scan? ☐ **YES** ☐ **NO**
Have you seen any other doctor(s) since the accident? ☐ **YES** ☐ **NO** Name _____
Have you missed any work since the accident? ☐ **YES** ☐ **NO** Date(s) _____
Did you ever experience similar symptoms prior to the accident? ☐ **YES** ☐ **NO**
Has your condition ☐ **IMPROVED** ☐ **WORSENED** or ☐ **STAYED SAME** since the accident?
Please share any other information that might be important to your diagnosis and treatment _____
_____

Insurance Information:
Insurance Company _____
Address _____ Phone _____
_____ Adjustor's Name _____
_____ Claim # _____
Utilization Company _____ Phone _____
Nurse _____ Fax _____

Patient Signature _____ **Date** _____

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Current Health Conditions

Name:_____ D.O.B._____

What is your major complaint? _____

When did symptoms start? _____

Who is your primary care physician?_____

Who referred you to physical therapy?: _____Date of Next Follow Up? _____

Have you fallen in the last 12 months? Y N How many times? _____

Have you received Physical Therapy in the last 12 months? _____

What would you like to achieve from physical therapy care? _____

_____

Please shade in the area(s) you are experiencing symptoms:

(Front) (Back)

Pain scale

At it's worst: 0 1 2 3 4 5 6 7 8 9 10

At it's best: 0 1 2 3 4 5 6 7 8 9 10

.

Pain is:

__achy __burning

__sharp __dull

__throbbing __other_____

Are there others in your family with same condition? **Y** **N**

Have you missed work because of your condition? **Y** **N**

If so, what dates? _____

Condition due to work? **Y** **N** Motor Vehicle Accident? **Y** **N**

If so, date of injury? _____ If so, date of injury? _____

Have you had major surgery? **Y** **N** If yes, what type? _____

_____

Have you had any major accidents or falls? **Y** **N** If yes, what type? _____

Have you ever been hospitalized for other conditions? _____

Have you been treated for other conditions in the past 12 months? **Y** **N**

If so, please explain: _____

List current medications including dosage _____

_____ _____

Patient's Initials_____

Acknowledgement of Office Policies

The following are Bay State Physical Therapy's policies governing appointment scheduling, payment terms, and information releases. ***Please read carefully*** *before signing, and be sure to ask questions you might have before signing the document.*

Appointment Scheduling. We at Bay State Physical Therapy are glad to accept insurance assignment on your behalf in handling your personal injury or worker's compensation claim. However, in order to help ensure that your insurance company pays for the care you receive here, it is important that you adhere to the recommended care program. We require a 24 hour cancellation notice for all appointments. If you miss three (3) appointments in a three (3) week period without notifying Bay State (emergencies considered), you may be dismissed from care and your file may be closed. *We only treat those patients who want to get well.*

Consent for Treatment. I, the undersigned, give Bay State Physical Therapy my permission to evaluate and treat my injury. I further understand that in the course of recommended treatment, condition may worsen on rare occasions. I further understand that no guarantee or promise has been made to me concerning the results of treatment.

Assignment of Payment. I hereby authorize my insurance company and/or my attorney to pay direct to Bay State Physical Therapy, PC any monies due on my account for professional services rendered.

Acknowledgment and Understanding. It is further understood that I, the undersigned, agree to pay the full amount of the charges should my condition be such that it is not covered by my policy, or if, for any reason, the insurance company and/or my attorney refused to pay my balance at this office.

Private Health Insurance. I understand that I am responsible for whatever fees my insurance company does not pay on my claim. (Typically, this includes deductibles and/or co-payments).

Authorization to Release Information. I authorize this office to release any information pertinent to my case to any insurance company or attorney to facilitate collections on my balance at this office.

Patient Requests for Records: I instruct the release of all medical, hospital, or surgical records pertinent to my case, including but not limited to exams, special test, x-rays, or lab results to this office.

I certify that I have read and understand all appointment and office policies listed above.

Patient Signature: _____ **Date:** _____

Name (Please Print): _____

Witness Signature: _____ **Date:** _____

Name (Please Print): _____

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Patient Information Consent Form

I have read and fully understand Bay State Physical Therapy's Notice of Information Practices. I understand that Bay State Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payments, understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operation if I notify the practice. I also understand that Bay State Physical Therapy will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Bay State Physical Therapy's Notice of information practices. I understand that I retain the right to revoke this consent by not signing the practice at any time.

_____
Patient Name

_____
Signature

_____
Date

BAY STATE
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Designate Individuals Authorization Form

I hereby authorize one or all of the designated parties listed below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Please give the name(s) of the individual(s) who you will allow to receive any part(s) of your health record.

Authorized Designees:

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

_____
Patient Name

_____
Patient Signature

PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal 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, for 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, we would be happy to address them.

I acknowledge that I have received a copy of Bay State Physical Therapy's *Notice of Privacy Practices for Protected Health Information.*

_____	_____
Patient Name Printed	Date
_____	_____
Patient Signature	Authorized Provider Rep.
_____	_____
Personal Representative Printed	Personal Rep. Signature

_____

Description of personal representative's authority to act for the patient

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BAY STATE
PHYSICAL THERAPY

Notice to Insurance Company of Assignment

To: _____

_____

_____

Adjustor: _____

Claim #: _____

You are instructed to pay directly to the provider at his/her office for all professional services rendered to me in this office.

This instruction to you is an assignment of my rights under medical coverage to the extent of this bill.

Any sum of money paid under this assignment shall be credited to my account and I shall be personally liable for any unpaid balance to the provider.

Pay to: Bay State Physical Therapy
535 South Main Street
Randolph, MA 02368

Phone: (781) 961-3370

Patient's Signature: _____ **Date:** _____

Patient's Name: _____

Patient's Address: _____

Street City State Zip

Witness Signature: _____

Acknowledgment of Insurance Company

This insurance company herby acknowledges receipt of the above instruction and agrees to mail payment of services rendered directly to the office of and to the order of the provider only.

Authorized Signature: _____ **Date:** _____

Note: If this acknowledgement is not signed and returned to the office of the provider within 7 days, and if the patient continues under treatment after 7 days, it will be assumed and relied upon that the company has agreed to coverage, and acknowledges payment directly to the provider.

Bay State Physical Therapy

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

Bay State Physical Therapy's LEGAL DUTY

Bay State Physical Therapy is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Bay State Physical Therapy uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example**, Bay State Physical Therapy** may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.
Bay State Physical Therapy may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.
In any other situation, **Bay State Physical Therapy**'s policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.
Bay State Physical Therapy may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.
You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. **Bay State Physical Therapy** will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that **Bay State Physical Therapy** may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on B**ay State Physical Therapy**'s health information practices or if you have a complaint, please contact the following person:

Bay State Physical Therapy
63 South Main Street, Randolph, MA 02368
Telephone: 781-961-9200 Fax: 781-961-6599