Northern Physical Therapy, PC

1. Personal Information.

Name _____ Date of Birth _____

Social Security Number _____ Male_____ Female_____

Mailing Address _____

Town _____ State _____ Zip _____

Physical Address _____

Town _____ State _____ Zip_____

Home Telephone _____ Work Telephone _____

Cell Phone _____

Primary Care Physician _____ Referring Physician_____

Emergency Contact _____ Telephone _____

E-Mail address:_____

A courtesy reminder is given to our patients one business day before your scheduled appointment.

Which contact option(s) would work best for you: phone text e-mail

2. Important Information.

A.

Is your diagnosis related to: *(Please circle Y or N)*	A work injury	Y	N	Date of Injury:
	A motor vehicle accident	Y	N	
	A liability claim	Y	N	

B. Have you received any PT/OT/Speech Therapy during the calendar year at any other facility? Y N

If so, where? _____ How long? _____

Was it for the same condition we are treating you for today? Y N

3. Insurance Information.

Primary Insurance:
Name of Insurance _____ ***(Please provide insurance card)***

Secondary Insurance (if applicable):
Name of Insurance _____ ***(Please provide insurance card)***

I certify the above information is correct to the best of my knowledge and I will notify Northern Physical Therapy immediately if there are any changes.

Signature_____ Date_____

When did you 1st think about us? ***Website*** ***Dr. Office*** ***Someone you know*** ***Other:***

Northern
PHYSICAL THERAPY

Benjamin McCormack, P.T., C.E.E.S.
Jennifer Jegacy-Gray, PT
Anthony Sgherza, P.T.
Emily Michaud, D.P.T.
Matthew Breton, M.P.T., O.C.S., C.S.C.S.

HIPAA DIRECTIVE

Consent for Release of Protected Healthcare Information

I, _____, allow Northern Physical Therapy, PC, with whom I share a confidential relationship with, to disclose to the following individuals (ie. family, friends, employers if workers' comp., attorney etc.):

1. _____
2. _____
3. _____
4. _____

Such information as they possess with respect to my care, freely and without limitation, including individual identifiable protected health information. Such individuals shall be considered my personal representative as defined in 45 CFR Section 164.502 of the regulation adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This authorization shall remain in effect for a period of one year from date of signature.

_____ _____

Signature **Date**

_____

Witness

Northern
PHYSICAL THERAPY

Cancellation Policy

Our number one priority is to help you improve your condition quickly and effectively. With the exception of a serious emergency, it is expected that you keep all your appointments so that we may service you to the highest level. If you need to reschedule an appointment, we require 24 hours notice. In such a case, please call our office and arrange for a make-up appointment with our front desk receptionist. The make-up appointment needs to be in the same week, preferably the very next day to help you receive the best results. In the instance of a cancellation without 24 hours notice or no-show to a scheduled appointment, we reserve the right to charge you a $35 fee. ***After two cancelled or missed appointments, we reserve the right to discontinue care.***

Insurance Referrals

If your insurance requires a referral from your Primary Care Physician, it is your responsibility to acquire that referral from your PCP. If your insurance company denies your visit due to the fact that a referral was not obtained, we reserve the right to bill you for that date of service.

Financial Policy

We will verify with your insurance carrier whether or not your insurance coverage indicates co-pays/coinsurances or a deductible. You are responsible for paying for services that fall under your deductible/coinsurance. All payments are due on the date of service.

Understand that you are responsible for paying Northern Physical Therapy, PC. directly for any applicable deductible/coinsurance/co-payment. This is a mandatory requirement when receiving healthcare services. Failure to meet your obligations is a violation of the agreement your insurance carrier and the carrier may take additional action. Please understand that if you have longstanding unpaid deductibles/coinsurance/co-payments, Northern Physical Therapy, PC will turn the account over to a collection agency. In the event that insufficient funds are received, we reserve the right to charge you the bank penalty fee and a $10 handling fee.

Benefit Assignment/Release of Information

I hereby assign all medical benefits to include major medical benefits, to which I am entitled including Medicare, private insurances, and third party payers to Northern Physical Therapy, PC. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records to secure payment. I also authorize the medical release of medical information to any other medical professional when appropriate.

Consent for Treatment

I give my consent for Northern Physical Therapy, PC to provide me with medical care and treatment considered necessary and proper in diagnosing or treating my physical condition.

Acknowledgement of Terms & Notice of HIPPA

My signature indicates that I have been notified of the privacy practices and a copy is available to me.
I have read and understood the above policies.

Patient or guardian signature: _____ Date: _____

Witnessed by Northern Physical Therapy Staff: _____ Date: _____

Northern
PHYSICAL THERAPY, P.C.

Benjamin McCormack, P.T., C.E.E.S.
Matthew Breton, M.P.T., O.C.S., C.S.C.S.
Emily Hill, D.P.T.
Anthony Sgherza, P.T.

Medical History Form

Patient Name _____ DOB _____

Allergies	Yes	No	Hepatitis	Yes	No
Anemia	Yes	No	High Cholesterol	Yes	No
Anxiety	Yes	No	High/Low Blood Pressure	Yes	No
Arthritis	Yes	No	HIV/AIDS	Yes	No
Asthma	Yes	No	Incontinence	Yes	No
Autoimmune Disorder	Yes	No	Kidney Problems	Yes	No
Cancer	Yes	No	Metal Implants	Yes	No
Cardiac Conditions	Yes	No	MRSA	Yes	No
Cardiac Pacemaker	Yes	No	Multiple Sclerosis	Yes	No
Chemical Dependency	Yes	No	Muscular Disease	Yes	No
Circulation Problems	Yes	No	Osteoporosis	Yes	No
Currently Pregnant	Yes	No	Parkinsons	Yes	No
Depression	Yes	No	Rheumatoid Arthritis	Yes	No
Diabetes	Yes	No	Seizures	Yes	No
Dizzy Spells	Yes	No	Smoking	Yes	No
Emphysema/Bronchitis	Yes	No	Speech Problems	Yes	No
Fibromyalgia	Yes	No	Strokes	Yes	No
Fractures	Yes	No	Thyroid Disease	Yes	No
Gallbladder Problems	Yes	No	Tuberculosis	Yes	No
Headaches	Yes	No	Vision Problems	Yes	No
Hearing Impairment	Yes	No			

Have you suffered from:

Injury as a result of a fall in the past year **Yes** **No**

Two or more falls in the last year **Yes** **No**

Describe any other conditions or precautions

Patient Name _____ DOB _____

Surgical History

Body Part/ Procedure: _____

| Right | Left | (If applicable) Approx. Month/Year_____

Body Part/ Procedure: _____

| Right | Left | (If applicable) Approx. Month/Year_____

Body Part/ Procedure: _____

| Right | Left | (If applicable) Approx. Month/Year_____

Body Part/ Procedure: _____

| Right | Left | (If applicable) Approx. Month/Year_____

Body Part/ Procedure: _____

| Right | Left | (If applicable) Approx. Month/Year_____

Current Medications

If you have a prescription medication list, please attach

Drug_____ Dose_____ Reason for taking_____
Drug_____ Dose_____ Reason for taking_____
Drug_____ Dose_____ Reason for taking_____
Drug_____ Dose_____ Reason for taking_____
Drug_____ Dose_____ Reason for taking_____
Drug_____ Dose_____ Reason for taking_____
Drug_____ Dose_____ Reason for taking_____
Drug_____ Dose_____ Reason for taking_____
Drug_____ Dose_____ Reason for taking_____
Drug_____ Dose_____ Reason for taking_____
Drug_____ Dose_____ Reason for taking_____
Drug_____ Dose_____ Reason for taking_____
Drug_____ Dose_____ Reason for taking_____