Patient Name: _____ **Date of Birth:** _____/_____/_____

Emergency Contact: Name: _____

Tel #: _____ **Relationship to patient:** _____

How did you hear about CMPT? _____

MEDICAL HISTORY

Where are you experiencing symptoms: _____ **Onset Date:** _____/_____/_____

What caused your symptoms: _____

Check if this problem occurred: ☐ **At Work** ☐ **In A Motor Vehicle Accident**

****Have you had ANY physical therapy in the last 12 months?** ☐ ***Yes -approximately how many visits*** _____ ☐ ***No***

Describe the nature of your pain: ☐ *Sharp* ☐ *Dull* Ache ☐ *Shooting* ☐ *Tingling* ☐ *Other*:_____

Current Pain (0-10): _____ **Pain at Worst** (0-10): _____ **Pain at Best** (0-10): _____

Have you had imaging (x-rays, MRI, CT Scan) for this problem? ☐ *No* ☐ *Yes (details):*_____

Occupation: _____

Recreational Activities/Hobbies:_____

Please check all of the following that apply to you: ☐ Pain at night ☐ Pain unrelieved by position or rest
☐ Arthritis ☐ Numbness ☐ Osteoporosis ☐ Dizziness / Fainting ☐ High blood pressure ☐ Diabetes
☐ Abnormal weight gain / loss ☐ Difficulty seeing or hearing ☐ Asthma / difficulty breathing ☐ Urinary problems
☐ Blood Disorder: _____ ☐ Cardiac Condition: _____ ☐ Cancer / Tumor: _____

Other health problems: _____

Current Medications (name & dosage): _____

Prior injuries (injury & date): _____

Prior surgeries (type & date): _____

HIPAA - Acknowledgement of Privacy Practices

I have received, read, and understand the notice of privacy practices which has provided a complete description of the uses and disclosures of my health information as outlined by the Health Insurance Portability and Accountability Act of 1996. I understand that I have certain rights regarding my protected health information and that this information can and will be used for purposes of treatment, payment and normal healthcare operations.

Consent to Treatment

I, the undersigned, a patient at Central Mass Physical Therapy & Wellness ("CMPT"), do hereby authorize the licensed physical therapy staff to administer treatment as necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained.

Patient Signature (Parent/Legal Guardian) _____

Relationship to Patient _____ Date:_____/_____/_____

Patient Name: _____ **Date of Birth:** _____/_____/_____

Email : _____

Mailing Address: _____

Street Town State ZipCode

Patient Coverage and Financial Responsibility

By signing below you understand and agree to all of the following:

ESTIMATED FINANCIAL RESPONSIBILITY EVALUATION: $ _____ FOLLOW-UP VISITS: $ _____

● I understand that health and/or accident insurance policies are an arrangement between the insurance carrier(s) and me. Furthermore, I understand that as a courtesy, CMPT will prepare insurance forms and will bill my insurance carrier(s). However, I am personally responsible for payment of services rendered to me.

Disclaimer*: the information we obtain from your insurance company- either from their website and/or over the phone from an insurance representative, is not a guarantee of accurate benefits or payment and we recommend that you also verify your benefits with your insurance company.*

● Any copayment, co-insurance, or a $50 prepayment toward my deductible, will be collected at the time of service. Accounts will be credited, if necessary, after claims are processed by insurance.
  - Until deductible is reached, I am responsible for all costs. During this time estimated pre-payments will be collected at each visit to break up the overall cost.
  - I am responsible to ensure that referrals and authorizations required by my insurance company are obtained. As a courtesy, CMPT will assist with this process. I may be financially responsible for the cost of visits that are denied by insurance.

● I agree to receive statements regarding any uncollected patient balances via email or text.

● I opt to have CMPT maintain my signature and credit card securely on file in my account and authorize CMPT to charge my credit card for any outstanding balances when they become due.

● I understand that CMPT reserves the right to discontinue treatment if an accumulating patient balance exceeds $150.00.

● I understand the cancellation / no show policy and understand that these charges may be added to my balance if applicable.

CANCELLATION/NO SHOW POLICY

Due to the high volume of patients and demands on our schedule,
and to remain consistent with our mission of providing one-on-one care,
we will be strictly enforcing the following cancellation/no show policy

★ For any cancellation made less than 24 hours before a scheduled appointment a $35 fee will be assessed.
★ A “No Show”, “No Call”, or missed appointment will be assessed a $75 fee.
★ The fee is charged to you–the patient, not the insurance company, and is due at the time of your next office visit.
★ Consecutive no-shows will result in automatic cancellation of all of your future appointments.

Patient Signature (Parent/Legal Guardian) _____

Relationship to Patient _____ Date:_____/_____/_____