Patient Information

Name: _____ Date of Birth: ____/_____/_____

Cell: _____ Home:_____

Address _____ Apt #: _____

City:_____State: _____ Zip Code: _____

SSN: _____ Email: _____

Emergency Contact:

Name: _____ Phone: _____

Relationship: _____

Employment Information:

Unemployed: ❑ Retired: ❑ Student (Grade):___

If employed, what do you do for work? _____

Phone number: _____

If workers comp, **please provide company name:** _____

Insurance Information:

***Skip this section if not applicable ***

Is this injury a result of a car accident: ❑ Is this injury a result of a work accident: ❑

Date of injury: ____/____/____

Attorney' name: _____ Phone:_____

Address: _____

Insurance Name: _____

Claim Number: _____

Patient Medical History

Do you have or have you ever had any of the following? Please check off all that apply.

❑ Arthritis	❑ Cancer	❑ Tobacco Use
❑ Heart of circulation problems	❑ HIV\Aids	❑ Numbness
❑ Pacemaker	❑ Stroke	❑ Diabetes
❑ Alcohol and or drug dependency	❑ Latex Allergies	❑ Vertigo
❑ Asthma	❑ Coordination problems	❑ Osteoporosis
❑ High blood pressure	❑ Frequent Falls	
❑ Epilepsy\Seizures	❑ Medication Allergies	
❑ Other:_____		

1. Have you had any surgeries in the area you were sent to therapy for? ❑**Yes** **No** ❑
2. Do you have any metal in your body? **If Yes**, Where? No ❑
   _____
3. List all medications you are currently taking?
   _____
4. Have you had physical therapy in the last 12 months? ❑ **Yes** **No** ❑
5. Do you currently exercise? No ❑ **If Yes**, How many times a week?
   _____

Impairment History:

1. Where is your pain\problem?
   _____
2. What caused your pain\problem?
   _____
3. What activities do you have difficulty doing because of your pain?
   _____
4. Have you ever had this pain\problem? If Yes, When? No ❑
   _____
5. How often do you experience your symptoms throughout the day?
   _____
6. Describe your pain: **Sharp** **Dull** **Burning** **Numb** **Cramping** **Electrical**
7. During the past week, please circle the worst pain you have had:
   No Pain: 0------1------2------3------4------5-----6------7------8------9------10 **Worst Pain**
8. Have you had any diagnostic test performed? No ❑ **If yes**, answer below.
   X-Ray Date:_____ Result: _____
   MRI Date: _____ Results: _____
   Other Test: _____ Date:_____ Results: _____

Consent for Treatment and Conditions of Services

1. Consent for Treatment: I hereby consent to treatment consisting of but not limited to, thermal mechanical and electrical modalities, manual therapies, and land or water based exercises and therapeutic procedures. My prognosis, diagnosis, as well as alternatives to treatment have been explained to me.

2. Assignment of Benefits & Authorization to Appeal: I hereby irrevocably assign and transfer to Dynamic Physical Therapy Services, DTPS, all rights, title, and interest in all benefits/money payable for services and supplies rendered. DPTS may appeal on my behalf for unpaid, delayed, or denied claims; however, I understand and agree this does not relieve me of my responsibility for any and all charges incurred.

3. Financial Policy: Primary Insurance: We file claims as a courtesy to you. However, if we do not receive payments within 90 days, you will be held responsible. The full balance is due upon receipt of invoice. We will not become involved in disputes between you and your insurance company regarding deductibles copayments, covered charges, secondary insurance, or "usual and customary", etc., other than to supply factual information as necessary to pay a claim. **Copays and deductible are due at time of visit. You may also be billed for non-covered charges.**

Automobile Medical Insurance: We will bill the automobile insurance company for your treatment provided that there is available coverage with the policy. If you do not have coverage, payment is due at time of your treatment. Will provide you with documentation at your request in order to facilitate reimbursement upon settlement of your case. **In the event of claim denial or fraud, you will become financially responsible for all treatment charges.**

Workers Compensation: We will bill your workers compensation carrier for yourcharges. **In the event of claim denial or fraud, you will become financially responsible for all treatment charges.**

Cash: Please pay balance in full at time of service.

Cancellation\No Show Policy: DPTS requires patients to provide 24 hours notification for all cancellations. DPTS reserves the right to charge you $25.00 for a cancellation within 2 hour prior to your schedule appointment time. DPTS reserves the right to charge you $50.00 for all no-show appointments. The charge will be billed to you directly and is not payable by insurance. We also reserve the right to refuse treatment for any client that has failed to show for three or more appointments. DPTS also reserves the right to cancel a scheduled appointment if the patient arrives more than 10 minutes after their appointment time. Cancelling is up to the discretion of the treating therapist and depends on a current scheduling. DPTS reserves the right to charge $25.00 for appointments that must be cancelled for late arrivals

4. Condition Precedent, Referrals, Pre-Certification, Pre-Authorization: It is the patient's responsibility to obtain any necessary referrals, pre-authorization, precertifications, or authorizations. I understand that failure to do so will leave me financially responsible for visits not covered by my insurance as a result of not obtaining referrals, or authorization prior to my visit.

5. Release of Medical Information/Medical Records: I consent and authorize DPTS to release information contained in any financial or medical records to the insurance company or their representatives, or any other entity responsible for payment or processing of the bills, any facility where the patient is receiving care, or to any federal, state, or governing agency.

6. Returned Checks for Insufficient Funds: The returned check (paper or electronic) issued to DPTS will result in $35.00 returned check fee being applied to the patient's account. The amount of the check plus $35.00 is payable at the next scheduled visit. DPTS will not accept checks from a patient after a check has been returned for insufficient funds.

7. Privacy Practice Notification : I have had a chance to review the facilities notice of Privacy practices and have read the document in full. I have been given the opportunity to discuss any concerns or questions regarding this policy.

The undersigned certifies that he/she has read and verbalized/demonstrated understanding of the foregoing, received a copy thereof and is the patient, the patient's legal representative, or is duly authorized by the patient to act as the patient's general agent to execute the above and accepted terms.

Date	Signature of patient\guardian	Printed Name

Dynamic Physical Therapy
111 Elm St, Suite 103 Worcester, MA
Phone 508: 799-6538 | Fax: 508-799-5535

Irrevocable Lien

I authorize and direct my current attorney and any successor or associated attorneys to withhold such sums equal to my outstanding balance $_____ at Dynamic Physical Therapy Services, resulting from my accident on ___/____/____ , from any claim, settlement, structured settlement, judgement, verdict or arbitration award which I may receive, as may be necessary to protect Dynamic Physical Therapy Services .I give an irrevocable lien on my accident case stemming from my accident on ___/___/___ to Dynamic Physical Therapy Services against any and all proceeds of any claim, settlement , structured settlement judgment, vereduct or arbitration award which may be paid to you, my attorney, and/or myself as a result of the injuries I sustained in the accident on ___/___/___. This authorization to withhold sums equal to my outstanding balance and to grant a lien to: Dynamic Physical Therapy Services, on my accident case applies both to claims against third parties and claims against my one, or any other, insurance coverage, including, but not limited to, so-called bodily injury to others, optional bodily injuries to other, uninsured and underinsured motorist benefits coverages.

I completely understand that i am personally and fully responsible to Dynamic Physical Therapy Services for all treatment incurred by me for treatment rendered even if an insurance company responsible for payment refuses to pay my bills. I realize that by signing this lien from, I am doing so only for, Dynamic Physical Therapy Services' additional protection. I also understand that full payment for all outstanding medical bills to Dynamic Physical Therapy Services , does not depend on any claim, settlement, judgement, verdict or arbitration award which I may recover.

Patient's name: _____ Date: ____/____/___

Patient's Signature: _____ Date: ____/____/___

Patient's Guardian: _____ Date: ____/____/___

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above agreement and agrees to withhold such sums from any claims; settlement judgement, verdict or arbitration award as may be necessary to adequately protect Dynamic Physical Therapy Services. I further agree to promptly forward to Dynamic Physical Therapy Services all PIP, Med Pay, worker's compensation, health disability or other similar payments received by me from any insurer to pay the outstanding balance. I agree to advise in writing any successor counsel, whose identity is known to me, of this lien. This lied form is signed in duplicate by the attorney.

Attorney's Signature: _____ Date: ___/___/___