FUNCTION FIRST
PHYSICAL THERAPY, INC.

540 Main Street, Suite 12 • Hyannis, MA 02601
508-778-4317 • Fax: 508-778-4376

Patient Information

Name:_____
Address:_____City:_____
State:_____ Zip Code:_____ Home Phone:_____Cell:_____
Date of Birth:_____ Social Security #:_____
Marital Status: Single/Married/Div/Sep/Widowed Sex: M F
Email:_____

Employer Name/School Name:_____
Above Address:_____City:_____
State:_____ Zip Code:_____ Work Phone:_____

Referring Physician:_____ Phone:_____
Primary Care Physician:_____ Phone:_____
Chose clinic because: Physician/Insurance/Family/Friend/Location/Yellow Pages/Other

Emergency Contact Name:_____
Phone Number:_____ Alternate Phone_____
Relationship:_____

Reason For Today's Visit:_____
Date of Injury:_____ N/A
Related to Job?: Yes No Related to Car?: Yes No Other Accident?: Yes No
Please Explain Injury:_____

Have you had physical therapy this calendar year?_____
If so where? _____
Insurance Information: Photocopies of my insurance cards have been made. ☐Yes ☐No

The above information is true to the best of my knowledge. As the responsible party, I agree that all charges that are not directly paid by my insurance company will be my responsibility.

Authorized Signature:_____
Today's Date:_____

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Medical History

Name:_____
Referring Physician:_____
Primary Care Physician:_____

Have you been diagnosed with any of the following? Check all that apply.

- ☐ Cardiac/Heart Problems:_____
- ☐ Pace Maker
- ☐ Stroke/TIA
- ☐ Impaired Circulation
- ☐ Osteoporosis
- ☐ Presently Pregnant
- ☐ Other:_____
- ☐ Pulmonary/Lung Problems:_____
- ☐ High Blood Pressure
- ☐ Diabetes ☐ Insulin Dependent
- ☐ DVT
- ☐ Metal Implant:_____
- ☐ Visual Problems

List any pertinent or recent injuries, surgeries, hospitalizations:

_____
_____
_____

List all current medications: ☐ List provided.

_____
_____
_____

OFFICE USE ONLY: ICD9:_____ Onset:_____

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Financial Policies

Financial Policy: Patients must recognize they are responsible for the charges incurred for the physical therapy (Worker's compensation excluded, although prior authorization is required.) We will submit billing to your insurance, free of charge for physical therapy services. You are responsible for knowing what your benefits are. In the event your insurance carrier does not submit payment for services rendered, a statement will be issued to you for payment.

Co-pays: Most HMO Health Plans have a co-payment per visit. Your insurance company sets the rate for co-payments. It is your obligation to pay the stated amount following each office visit.

Lien of Personal Injury: If you were involved in a motor vehicle accident, we will submit billing to your PIP and Med Pay insurance. If you have retained an attorney our office must receive a signed lien by the patient and the attorney.

Attendance Policy: If you must cancel your appointment, we ask you to call 24 hours in advance. You will be charged a $35.00 Fee (Patient's initials_____) if you fail to cancel an appointment 24 hours in advance. We have an answering machine where you can leave a message if we are unavailable when you call.

Assignment of Benefits/Authorization to Release Medical Information/ Consent to Evaluate and Treat

I hereby assign all medical benefits to which I am entitled to Function First Physical Therapy, Inc. in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is default of payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt. This includes but is not limited to collection service fees, attorney's fees, and all court costs and additional legal fees associated with the recovery of this debt. Interest may be charged at a rate of 1.5% per month (18% annually) for unpaid balances over 90 days old. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such evaluation and treatment by the authorized personnel of Function First Physical Therapy, Inc. as may be dictated by prudent medical practice by my illness, injury or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

HIPAA Acknowledgement

I have read and fully understand Function First Physical Therapy, Inc.'s HIPAA policy. I understand that Function First Physical Therapy, Inc. may use or disclose my personal health information for the purposes of treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the Corporation in writing. I also understand that Function First Physical Therapy, Inc. 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 Function First Physical Therapy, Inc. Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the Corporation in writing at any time.

Patient Signature _____
Name Date

If party is a minor_____
Name of Parent/Guardian Date

SIGNATURE CONSTITUTES ACCEPTANCE OF ABOVE POLICIES