Balanced Motion Physical Therapy

290 Littleton Road, Suite 3
Chelmsford, MA 01824
Phone: 978-251-4860
Fax: 978-923-8655

Patient Information Form

Today's Date _____ Date of Birth_____ Age_____ Gender: M F

Last Name_____ First Name_____ Middle Initial_____

Address _____ City, State Zip _____

Home Phone_____ Mobile Phone_____ Work Phone _____

Email Address_____ Preferred method of contacting you_____

Referring Physician_____ Primary Physician (*if different from referring*)_____

Employer_____ Work Address_____

Are you here because of an accident? Yes No **Were you injured at work?** Yes No **Date of Injury**_____

If yes, explain _____

Insurance Information

Policy Holder Information

Policy Holder_____ _____ _____
Last Name First Name Middle Initial

Policy Holder Date of Birth_____ Relationship to Patient_____

Policy Holder Address _____ Home Phone:_____
(if different from patient)

Policy Holder Employer_____ Work Address_____

Primary Insurance

Insurer:_____ Policy /Group Number _____

Phone_____ Address _____
From back of card

Secondary Insurance (if applicable)

Policy Holder _____ Relationship to Policy Holder_____

Policy Holder Date of Birth_____ Insurer:_____ Phone _____

Policy/Group Number_____ Address _____
From back of card

Emergency Contact

Name_____ Phone Number_____

Relationship to Patient_____

How did you hear about Balanced Motion Physical Therapy?_____

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Authorization for Treatment

Informed consent for treatment:
The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to you. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

I hereby consent to and authorize all physical therapy treatments at Balanced Motion Physical Therapy.

Patient*: _____ _____
Signature * *Must be 18 years or older to sign* **Date**

Parent/Guardian: _____ _____
Signature/Relationship **Date**

Financial Agreement

I understand and agree that I am responsible for payment for services performed at Balanced Motion Physical Therapy. I agree to pay for my treatment; either for the total balance or applicable copay, at time of service, by cash, or check, unless other mutually agreed upon arrangements have been made. Insurance: I understand it is my responsibility to call my insurance company ahead of time, and obtain any pre-authorization that is necessary, and get an estimate of my benefits. Out-of-network insurance: I understand my therapist will provide me with a receipt and that it is my responsibility to submit to my insurance company. In-network insurance: I authorize all payments be made from my insurance company to Balanced Motion Physical Therapy and I am responsible for all charges not paid by my insurance company. I authorize Balanced Motion Physical Therapy to provide information necessary to secure payment of benefits. Please initial_____

Cancellation/No Show Policy

No-show, missed appointments, or cancellations with less than 24 hours advance notice will incur a $60 fee.
I understand that I will NOT be charged if I cancel or reschedule my appointment with more than 24 hours notice. I agree to pay a fee of $60 if I fail to show up for my scheduled appointment. If I reschedule or cancel with less than 24 hours advance notice, a $60 fee will be incurred. Under special circumstances, and at the discretion of the therapist, this $60 fee may be waived. It is the policy of this clinic that after 3 cancelled or missed appointments, you will be an automatically discharged from our office and a letter will be sent to your referring physician. Please initial_____

Use of Protected Health Information

I have been provided with a Notice of Information Practices. I understand that Balanced Motion Physical Therapy may disclose my personal health information for the purpose of carrying out treatment and obtaining payment. I hereby consent the use and disclosure of my personal health information as described in the Notice of Information Practices. I understand I can revoke this consent by notifying the practice in writing at any time. Please initial____

Release of medical records:
I authorize the release of my medical records to the following physician/provider or insurance company;

_____

I have read the above information and I agree to these terms and conditions and consent to physical therapy treatment.

_____ _____ _____
Print Name Signature Date

Therapist Signature_____ Date:_____

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Patient Health History

Patient name _____

Page 1

Date of Birth _____

Medical / Surgical History

Please check if you have ever had (check all that apply):

- ☐ Arthritis
- ☐ Heart attack
- ☐ Stroke
- ☐ Asthma/Lung problems
- ☐ Cancer
- ☐ Kidney problems
- ☐ Parkinson's disease
- ☐ Skin diseases
- ☐ Allergies *(list)*:_____
- ☐ Broken bones / fractures
- ☐ Circulation / vascular problems
- ☐ High blood pressure
- ☐ Diabetes / high blood sugar
- ☐ Multiple Sclerosis
- ☐ Seizures or epilepsy
- ☐ Thyroid problems
- ☐ Infectious disease *(MRSA/tuberculosis, hepatitis)*
- ☐ Other: _____
- ☐ Osteoporosis
- ☐ Heart problems
- ☐ Pacemaker
- ☐ Hypoglycemia / low blood sugar
- ☐ Developmental/growth problems
- ☐ Ulcers / stomach problems
- ☐ Depression

Within the past year, have you had any of the following symptoms? (Check all that apply)

- ☐ Chest pain
- ☐ Headaches
- ☐ Coordination problems
- ☐ Difficulty walking
- ☐ Difficulty sleeping
- ☐ Difficulty swallowing
- ☐ Hearing problems
- ☐ Bowel problems
- ☐ Shortness of breath
- ☐ Weakness in arms or legs
- ☐ Joint pain or swelling
- ☐ Loss of appetite
- ☐ Weight gain
- ☐ Vision problems
- ☐ Urinary problems
- ☐ Dizziness or blackouts
- ☐ Loss of balance
- ☐ Pain at night
- ☐ Fever / chills / sweats
- ☐ Weight loss
- ☐ Other:_____

MEN: Prostate disease? Yes No

WOMEN: Are you pregnant or think you might be pregnant? Yes No
Diagnosed with other OB/GYN difficulties? Yes No
Have you ever had surgery related to women's health? Yes No

Procedures/Surgery	**Date(s)**	**Describe**
Orthopedic Surgery		
Heart Surgery		
Fractures		
C-Section		
Child Birth		

Have you ever had Physical Therapy *(if Yes for what?)*:_____

Medications *(Please list all medications you are currently taking, including over the counter medications/vitamins/supplements)*

Medication Name	Dose	D/C Date

Medication Name	Dose	D/C Date

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Patient Health History

Page 2

Patient name _____

Date of Birth _____

Current Conditions / Chief Complaints

When did your current problem(s) begin? (Month/year) _____/_____

Have you ever had this problem before? Yes / No / Chronic ***If yes*:** How long did the problem(s) last? _____

How did it start/What happened? _____

What did you/have you done for the problem(s)? _____ Did it get better? Yes No

How are you taking care of the problem(s) now?_____

What are your goals for physical therapy? _____

Are you seeing any healthcare providers for your current problem(s)? (Please list) _____

Symptoms

Please describe your symptoms now _____

Please describe your pain at onset: *(numbness, tingling, aching, burning, sharp)*_____

Please describe your pain currently: _____

Has your pain gotten better/ worse or stayed the same since onset:_____

Please mark on lines below:
Current average pain

0 1 2 3 4 5 6 7 8 9 10
None *Mild* *Moderate* *Severe* *Very Severe*

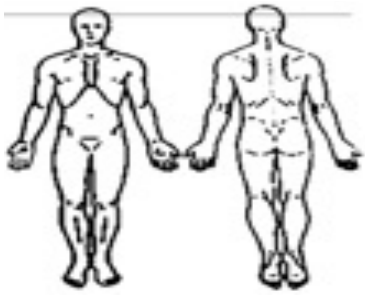
Worst pain *(at its absolute worst, how high?)*

0 1 2 3 4 5 6 7 8 9 10

Best pain *(on a really good day, how low does it go)*

0 1 2 3 4 5 6 7 8 9 10

Please mark on the diagram where your symptoms are located



Diagnostic Testing

Diagnostics	Yes	No	Date	Findings
X-Rays				
MRI				
CT Scan				
Injections				
NCV (nerve conduction velocity)				

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Consent for Use and Disclosure of Protected Health Information

Purpose of Consent: *This Consent for the use and/or disclosure of personally identifiable health information is made pursuant to the requirements of 42 C.F.R. §164.506, which sets out the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").*

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Balanced Motion Physical Therapy, LLC. (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the regulations.
2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Consent, I understand and acknowledge that I have the right to review the Privacy Notice prior to signing this Consent.
3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: 290 Littleton Road, Suite 3; Chelmsford MA 01824.
4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

   I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions): _
   _____
5. I understand and acknowledge that I may revoke this Consent at any time by sending a written revocation to the Practice at the address set forth in (3) above. However I also understand and acknowledge that if I revoke this Consent, my revocation will not be effective to the extent that the Practice has already acted action in reliance on this Consent.

I understand the foregoing provisions, and I wish to sign this Consent authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

Disclosure of Protected Health Information by Facsimile

Please read the following information carefully:

- I understand that one method of transfer of Protected Health Information (PHI) will be by facsimile (FAX).
- I understand that communication of PHI between health care providers and others may be necessary for the adequate and efficient treatment of patients. Records containing health information, history, symptoms, test results, diagnose, treatment and claims may be included.
- I agree that only representatives authorized by the Balanced Motion Physical Therapy, LLC. (the "Practice"), its agents and employees or its specified Business Associates and their agents and employees will request PHI or be provided with PHI to facilitate necessary communications.
- I understand and acknowledge that the PHI disclosed by the Practice will only be used for treatment, payment,health care operations and services.
- **I acknowledge that the facsimile machine receiving the PHI is in a protected area which limits access to authorized individuals only. I also acknowledge that all PHI received will be protected in accordance with application statutes and regulations, including, but not limited to the Privacy Regulations and applicable state and federal laws.**

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED THIS CONSENT AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

_____ _____ _____
Signature of Patient or Representative | Patient's Printed Name | Date

_____ _____
Printed Name of Personal Representative (if applicable) | Relationship to Patient

To Be Completed by Balanced Motion Physical Therapy, LLC.

The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:

_____ Accepted _____ Denied ____ Not Applicable ____Other***(explain)***_____

_____ _____
Signature of Authorized Clinic Representative | Date

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Snow/Inclement Weather Cancellations/Rescheduling

Winter weather is a part of living in New England and with winter weather upon us, please note the following Weather Cancellation Policy for BMPT:

1. Your safety is of the first and most importance.

You should not knowingly jeopardize your safety to travel on dangerous and unsafe roads or to travel when the state police advise against it. We also feel that you should not travel if you feel it is not in your best interest, due to physical limitations or personal comfort in driving in inclement weather. Please contact us if you feel it is unsafe for you to get to your appointment and your appointment will be rescheduled. No fees will be issued for cancellations or rescheduling due to weather, at any time, provided you contact us ***prior*** to your appointment. Every effort will be made to reschedule your appointment as soon as possible.

2. If the Chelmsford, Groton/Dunstable, Tyngsboro and/or Westford Public Schools cancel school for the day due to weather related issues, Balanced Motion Physical Therapy will be closed for the day.

Your therapist will contact you directly should she decide to hold appointments as scheduled. If you do not hear from us and one or all of these school districts are closed you should assume your appointment has been cancelled. In the case of power outages, the clinic must, by law, be closed for the duration of the power outage event. Power outages in the surrounding communities may affect our abilty to be open. If you are unsure, please contact your therapist directly.

3. Our website will be updated with closure of the office by 7:00am.

Should you have an early morning appointment and the website is not updated, please feel free to contact your therapist directly or leave a message on the office phone. The office voicemail ***WILL NOT*** be updated with closures.

Patient Signature	Print name	Date