4 Middlesex Road, PO Box 593
Tyngsboro, MA 01879
Phone: 978-807-1042
Fax: 978-923-8655

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 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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Patient Health History

Patient name ______________________________

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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

Patient name ______________________________

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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*

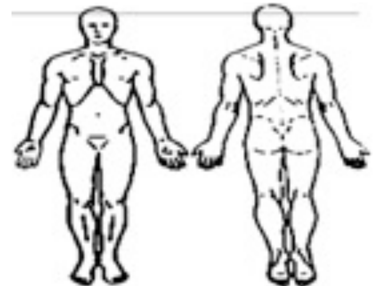
Worst pain *(at its absolute worst, how high?)*

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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