

BACKSTAGE PT

Dance, Orthopedic & Sports Physical Therapy

PATIENT REGISTRATION (Please Print)

Today's date:		Referring Physician:		Physician phone no.: ()	
PATIENT INFORMATION					
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Married / Divorced / Sep / Widow
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):		Birth date: / /	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:	Home phone no.: ()	
Employer:				Employer phone no.: ()	
Chose clinic because/Referred to clinic by (please check one box):			<input type="checkbox"/> The Skating Club of Boston	<input type="checkbox"/> Charles River Gyrotonic ®	<input type="checkbox"/> Dr.
<input type="checkbox"/> Website	<input type="checkbox"/> Boston Dance Alliance	<input type="checkbox"/> Other Please describe:			

INSURANCE INFORMATION

(Please give your insurance card/photo ID to the front desk)

Person responsible for bill:	Birth date: / /	Address (if different):		Home phone no.: ()	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Patient will be SELFPAY (please initial) X_____					
*Please indicate primary insurance:					
* Backstage PT DOES NOT participate with many Private/Government Health Programs; Patient must have OUT of NETWORK Benefits.					
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ()	Work phone no.: ()
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize <u>Backstage PT or insurance company</u> to release any information required to process my claims.			
Patient/Guardian signature:		Date:	

BACKSTAGE PT

Dance, Orthopedic & Sports Physical Therapy

Medical History

Patient Name: (please print)	Date
------------------------------	------

Date of Birth: ____/____/____

Male Female

1. Height _____ Weight _____ 2. Occupation _____

3. Do you have any customs, or religious beliefs that might affect your care? Yes No

If yes, please describe: _____

4. Describe the problem(s) for which you seek physical therapy:

5. When did this problem(s) begin? Date: ____/____/____

What happened? _____

6. Have you ever had this problem(s) before? Yes No If yes, when: _____

How did you treat this before? _____

7. What makes the problem(s) feel better?

8. What makes the problem(s) feel worse?

9. What are your goals for physical therapy?

10. Do you exercise on a regular basis? Yes No

If yes, what activities and how often? _____

11. Do you have family members who have or had any of the following conditions?

	Relationship to You		Relationship to You
Heart Disease		Stroke	
Hypertension		Osteoporosis	
Cancer		Diabetes	
Arthritis		Other	

12. Have you ever had surgery? Yes No If yes, when: _____

For what injury/condition(s)? _____

13. Have you had any previous fractures? Yes No If yes, when: _____

What body part(s)? _____

14. Do you have any metal plates, screws, or other devices (pacemaker, etc.) surgically implanted? Yes No

If yes, please describe: _____

15. Do you take any medication(s) on a regular basis? Yes No

If yes, please list: _____

16. Do you have any other conditions which you think might be relevant for today's evaluation?



INFORMED CONSENT FOR PHYSICAL THERAPY

Physical therapy involves the use of many different types of physical evaluation and treatment. At Backstage Physical Therapy, we use a variety of procedures, and modalities to try and improve your function. As with all forms of medical treatment, there are benefits, and risks involved with physical therapy.

Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain therapy modality, or procedure. We are not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause discomfort, or may aggravate previously existing conditions.

You have the right to ask your physical therapist what type of treatment he, or she is planning based on your history, diagnosis, symptoms, and testing results. You may also discuss with your therapist what the potential risks, and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time before, or during your treatment session.

Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing, and any specific risks associated with your exercises, your therapist will be glad to answer them.

I understand the risks associated with a program of Physical Therapy as outlined to me, and I wish to proceed.

Please Print Patient Name: (if parent or legal guardian please print your name after the patient's)	
Patient Signature:	Date



FINANCIAL POLICY

Backstage PT is committed to providing you with the best possible physical therapy care. The timely payment of your bill is an essential part of your treatment. The patient will be responsible for all ***copay, deductible, and coinsurance amounts due at the time services are rendered.*** Our office accepts cash, checks and Visa, MasterCard credit cards (including Health Savings Account cards).

IF MY INSURANCE PAYS ME DIRECTLY

- I agree to forward the payment to this office within **10 days of my receipt of payment.**
- Failure to comply with this agreement may lead to legal action to collect the account.

You are financially responsible for all fees incurred for services rendered regardless of insurance.

- After 60 days a rebilling fee of **\$25.00** will be assessed.
- After 90 days a rebilling fee of **\$50.00** will be assessed.
- After 100 days the account will be turned over to a Third Party Billing Service.

Self-Pay Patients:

(You are considered a self-pay patient if you fall into one of the following categories)

- You **DO NOT** have **OUT of NETWORK** insurance coverage/or any health insurance.
- You do not have any health insurance coverage.
- You have a MA Health, or any Medicaid Coverage.
- You are seeking care due to an automobile accident.

Additional Patient Fees:

- **50% of the balance** due will be assessed to the account if account is turned over to collections
- Collection fees, attorney fees, and court costs incurred by the collection of all sums due.
- **\$35.00** will be charged for any returned check.
- Any supplies, or durable medical equipment (DME)
- **\$50.00** Late Cancellation Fee. (24 hours notice is required.)
- **\$50.00** Missed Appointment Fee.

I have read this financial policy. I understand, and agree to comply with this financial policy. I authorize the release of any medical information required throughout the course of examination and treatment and permit payment directly to Backstage PT for any monies due for the services rendered. I understand that this office will make every attempt to obtain payment from my insurance carrier including Medicare and/or other third party payer.

Please Print Patient Name: (if parent or legal guardian please print your name after the patient's)	
Patient Signature:	Date
Witness: (print name)	
Witness Signature:	Date



FINANCIAL POLICY-PATIENT COPY

Backstage PT is committed to providing you with the best possible physical therapy care. The timely payment of your bill is an essential part of your treatment. The patient will be responsible for all *copay, deductible, and coinsurance amounts due at the time services are rendered*. Our office accepts cash, checks and Visa, MasterCard credit cards (including Health Savings Account cards).

IF MY INSURANCE PAYS ME DIRECTLY

- I agree to forward the payment to this office within **10 days of my receipt of payment**.
- Failure to comply with this agreement may lead to legal action to collect the account.

You are financially responsible for all fees incurred for services rendered regardless of insurance.

- After 60 days a rebilling fee of **\$25.00** will be assessed.
- After 90 days a rebilling fee of **\$50.00** will be assessed.
- After 100 days the account will be turned over to a Third Party Billing Service.

Self-Pay Patients:

(You are considered a self-pay patient if you fall into one of the following categories)

- You **DO NOT** have **OUT of NETWORK** insurance coverage/or any health insurance.
- You do not have any health insurance coverage.
- You have a MA Health, or any Medicaid Coverage.
- You are seeking care due to an automobile accident.

Additional Patient Fees:

- **50% of the balance** due will be assessed to the account if account is turned over to collections
- Collection fees, attorney fees, and court costs incurred by the collection of all sums due.
- **\$35.00** will be charged for any returned check.
- Any supplies, or durable medical equipment (DME)
- **\$50.00** Late Cancellation Fee. (24 hours notice is required.)
- **\$50.00** Missed Appointment Fee.

I have read this financial policy. I understand, and agree to comply with this financial policy. I authorize the release of any medical information required throughout the course of examination and treatment and permit payment directly to Backstage PT for any monies due for the services rendered. I understand that this office will make every attempt to obtain payment from my insurance carrier including Medicare and/or other third party payer.

Please Print Patient Name: (if parent or legal guardian please print your name after the patient's)	
Patient Signature:	Date
Witness: (print name)	
Witness Signature:	Date



MINOR CONSENT FOR TREATMENT

I, _____, (please print name) hereby give my permission as parent/guardian for the minor child, _____, (please print name) to receive treatment from Backstage PT.

In consideration of my minor child's participation in Physical Therapy services with Backstage PT, _____, (please print name) hereby release Backstage PT (its employees and owners), from any claims, demands, and causes of action arising from my minor child's participation in the Physical Therapy program.

I, _____, (please print name) hereby release Backstage PT from liability now, and/or in the future during the treatment of my minor child, _____ (please print name).

"I understand that, in my absence, my minor child will make decisions regarding Physical Therapy services and I will be responsible for all charges associated with those services."

"I hereby affirm that I have read and fully understand the above."

Please Print Patient Name: (if parent or legal guardian please print your name after the patient's)	
Patient Signature:	Date
Witness: (print name)	
Witness Signature:	Date