PATIENT DEMOGRAPHICS: INTAKE FORM

Name: _____ Preferred First Name:_____

Sex: _____ Preferred Pronouns: _____Date of Birth: _____

StreetAddress:_____

City:_____ State:_____ Zip:_____

What is the best way to contact you? _____

Preferred Phone #:_____ Email:_____

Occupation:_____

****Have you had ANY physical therapy in the last 12 months? □ *Yes -approximately how many visits_____* □ *No***

REFERRAL INFORMATION

How did you hear about us?_____

Referring Physician:_____ Phone #:_____

Primary Care Physician:_____ Phone #:_____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name:_____ Relationship:_____

Home Phone #:_____ Cell Phone #:_____

MEDICAL HISTORY: INTAKE FORM

Where are you experiencing symptoms:_____

What caused your symptoms: _____

Onset Date: _____ **Check if this problem occurred: □ At Work or □ In A Motor Vehicle Accident**

Describe the nature of your pain: □ *Sharp* □ *Dull* Ache □ *Shooting* □ *Tingling* □ *Other*:_____

Current Pain (0-10):_____ **Pain at Worst** (0-10):_____ **Pain at Best** (0-10):_____

Have you had imaging (x-rays, MRI, CT Scan) for this problem? □ *No* □ *Yes (details):*_____

Recreational Activities/Hobbies:_____

Please check all of the following that apply to you:

□ Pain at night □ Asthma / difficulty breathing □ Diabetes □ Numbness □ Difficulty seeing or hearing
□ Blood Disorder: _____ □ Arthritis □ High blood pressure □ Cardiac Condition: _____
□ Osteoporosis □ Abnormal weight gain / loss □ Cancer / Tumor: _____ □ Dizziness / Fainting
□ Pain unrelieved by position or rest □ Urinary problems
Other health problems: _____

Current Medications (name & dosage) _____
Prior injuries (injury & date): _____
Prior surgeries (type & date): _____

Acknowledgement of Privacy Practices
I have received, read, and understand the notice of privacy practices which has provided a complete description of the uses and disclosures of my health information as outlined by the Health Insurance Portability and Accountability Act of 1996. I understand that I have certain rights regarding my protected health information and that this information can and will be used for purposes of treatment, payment and normal healthcare operations.

Consent to Treatment
I, the undersigned, a patient at Central Mass Physical Therapy & Wellness ("CMPT"), do hereby authorize the licensed physical therapy staff to administer treatment as necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained.

Patient Coverage and Financial Responsibility
I understand and agree that health and/or accident insurance policies are an arrangement between the insurance carrier(s) and me. Furthermore, I understand that CMPT will prepare insurance forms, and will bill my insurance company as a courtesy. However, I clearly understand that I am personally responsible for payment for services rendered to me.

Deductibles/Co-Insurance and/or Co-payments/Marketing:

- Any copayment, co-insurance, or a $50 prepayment toward my deductible, will be collected at the time of service. Accounts will be credited, if necessary, after claims are processed by insurance.
- I agree to receive statements regarding any uncollected patient balances via email or text.
- I give permission to receive marketing emails from CMPT, I can opt out/unsubscribe at any time.
- If I opt to have CMPT maintain my signature and credit card information securely on-file in my account, I authorize CMPT to charge my credit card for any outstanding balances when they become due.
- I understand that CMPT reserves the right to discontinue treatment if an accumulating patient balance exceeds $150.00.

Insurance Referrals
Patients are responsible to ensure that referrals and authorizations required by insurance companies are obtained. As a courtesy, CMPT will assist patients with this process. Patients will be held responsible for the cost of visits that are denied by insurance because a referral or authorization was not obtained.

By signing below you are agreeing to acknowledgement of privacy practices along with all of the terms and conditions listed above.

Printed Name: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

CENTRAL MASS
Physical Therapy & Wellness

CANCELLATION/NO SHOW POLICY:

Thank you for entrusting CMPT with your Physical Therapy Care!

Due to the high volume of patients and demands on our schedule, and to remain consistent with our mission of providing one-on-one care, we will be strictly enforcing the following cancellation/no show policy, **effective July 1, 2023.**

- ★ **For any cancellation made less than 24 hours before a scheduled appointment a $35 fee will be assessed.**
- ★ **A "No Show", "No Call", or missed appointment will be assessed a $75 fee.**
- ★ **The fee is charged to you–the patient, not the insurance company, and is due at the time of your next office visit.**
- ★ **Consecutive no-shows will result in automatic cancellation of all of your future appointments.**

By signing below I am indicating I have read, understand, and agree to comply with the CMPT no show and cancellation policy.

Patient Signature (Parent/Legal Guardian)_____

Relationship to Patient_____

Date:_____/_____/_____