concierge PHYSICAL THERAPY

PATIENT INFORMATION:

Patient Name: _____ **Sex:** Male or Female

Date of Birth: _____

Parent(s) Name: _____

Address: _____
Street Town/City State Zip Code

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Email Address: _____

Referring Physician: _____ **Phone Number:** _____

Primary Care Physician: _____ **Phone Number:** _____

How did you hear about us?: **Google** **Facebook** **Newspaper** **MD Referral** **Word of Mouth**
(Please circle your choice)

Other: _____

INSURANCE INFORMATION:

Primary Insurance: _____ **Phone Number:** _____

Policy Number: _____ **Group Number:** _____

Subscriber: _____ **Date of Birth:** _____ **Relationship:** _____

Secondary Insurance: _____ **Phone Number:** _____

Policy Number: _____ **Group Number:** _____

Subscriber: _____ **Date of Birth:** _____ **Relationship:** _____

PATIENT MEDICAL HISTORY

Reason for Visit: _____

Date Symptoms Began : _____

List Current Medications & Allergies (or provide a copy): _____

_____

Was your child born to term?: ***Yes / No***

If no: _____

Does your child have a history of hospitalizations?: ***Yes / No***

If yes: _____

Has your child received Early Intervention Care?: ***Yes / No***

If yes: _____

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Has your child received In-School Physical Therapy?: ***Yes / No***

If yes: _____

Does your child require Occupational Therapy or Speech Therapy?: ***Yes / No***

If yes: _____

Does your child have a history of surgery?: ***Yes / No***

If yes: _____

Were there any complications with childbirth?: ***Yes / No***

If yes: _____

Have your child had Physical Therapy in the last year? If so, for what and where?

_____

How does your child best communicate?:

_____

If your child has any challenges with following instructions, please detail them below:

_____

What are some of your child's interests?

_____

What are their daily activities? _____

Does your child participate in any extracurricular activities?

_____

Do your child have a history of falls? (Circle) Yes / No

*If Yes, when was your last fall? _____

PAST SURGICAL HISTORY

Type of Surgery: _____ **Date:** _____

Type of Surgery: _____ **Date:** _____

_____

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Pediatric Questionnaire::

Does your child current have or have a history of: (Check all that apply)

_____ ADD/ADHD
_____ ASD
_____ Cerebral Palsy
_____ Colic
_____ Concussion
_____ Scoliosis
_____ Other: _____

_____ Seizures
_____ Sensory Concerns
_____ Spina Bifida
_____ Scoliosis
_____ Stroke
_____ Trouble Eating/ Picky Eater

At what age did your child perform the following?

Crawl: _____
Cruise: _____
Jump: _____
Ride a bike/ Tricycle: _____

Roll: _____
Skip: _____
Sit Independently: _____
Walk Independently: _____

Which of the following activities are challenging for your child?

_____ Jumping
_____ Running
_____ Skipping
_____ Climbing
_____ Other

Have you had any of the following, medical, or rehabilitative services for this injury/episode? (Please check those that apply)

_____ MRI Date: _____
_____ CT Scan Date: _____
_____ X-Rays Date: _____
_____ EMG/NCV Date: _____
_____ Chiropractor Date: _____

_____ Neurologist Date: _____
_____ Podiatrist Date: _____
_____ Massage Therapy Date: _____
_____ Occupational Therapy Date: _____
_____ Othopedist Date: _____
_____ Other: _____ Date: _____

POLICY DISCLOSURES

HIPAA STATEMENT

I understand that Concierge Physical Therapy, Inc. will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payment. *I have received and read the HIPAA statement provided.*

Patient Signature: _____
Parent/Guardian Signature
(if patient is under 18) _____

WAIVER OF RELEASE OF LIABILITY

In agreeing to receive care provided by Concierge Physical Therapy, Inc. ("CPT") and to use the facilities provided therefore by CPT at 64 Worcester Providence Turnpike in Sutton, MA 01590, 307 Grafton Street Shrewsbury, MA 01545, 22 South Street, Hopkinton, MA 01748, I agree as follows: I fully understand and acknowledge that (a) the activities in which I will engage as part of the treatment provided by CPT and the physical therapy activities and equipment that I may use as a part of that treatment have inherent risks, dangers, and hazards and such exists in my use of equipment and my participation in these activities; (b) my participation in such activities and/or use of such equipment may result in injury or illness including, but not limited to bodily injury, disease, strains, fractures, partial and/or total paralysis, death or other ailments that, could cause serious disability; (c) these risks and dangers may be caused by the negligence of the representatives or employees of CPT the negligence of the participants, the negligence of others, accidents, breaches of contract, or other causes. By my participation in these activities and for use of equipment, I hereby assume all risks and dangers and all responsibility for any losses and/or damages whether caused in whole or in part by the negligence or the conduct of representatives or employees of CPT, or by another person. I on behalf of myself, my personal representatives and my heirs, hereby voluntarily agree to release, waive, discharge, hold harmless, defend, and indemnify CPT, Inc., and their representatives, employees, and assigns from any and all claims, actions or losses for bodily injury, property damage, wrongful death, loss of services or otherwise which may arise out of my use of any equipment or participation in these activities. I specifically understand that I am releasing, discharging, and waiving any claims or actions that I may have presently or in the future for the negligent acts or other conduct by the representatives or employees of CPT. I have read the above waiver & release and by signing it agree to the terms therein. It is my intention to exempt and relieve Concierge Physical Therapy from liability for personal injury, property damage and wrongful death caused by negligence or any other cause.

Patient Signature: _____
Parent/Guardian Signature
(if patient is under 18) _____

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POLICY DISCLOSURES

ATTENDANCE POLICY

We strive to provide you with the best, personalized care available. To make this possible we adhere to a set of very important policies.

24-hour Cancellation Notice: If you wish to change or cancel your appointment we require a minimum of 24-hour advance notice. Anything less than that will result in a **$50.00 fee** applied to your account. We charge **$50.00** not to make money, but to act as a deterrent from making last minute changes. Please be courteous and responsible. Thank you.
No Shows: We understand things happen. If you are unable to keep an appointment please call and let us know. Simply not showing up will result in the loss of all scheduled future appointments. New appointments will be allowed on a "first-come, first-serve basis". **ALL NO SHOWS WILL BE CHARGED A FEE OF $100.00.**

I have carefully read and agree to all of the above policies. In the event such policies are broken, I agree to the consequences set forth. Please sign that you have read these policies:

Patient Signature: _____
Parent/Guardian Signature
(if patient in under 18) _____

AN IMPORTANT MESSAGE REGARDING PAYMENT FOR THERAPY SERVICES

We strongly recommend that you contact your insurance company to verify the benefits we have been quoted below. Be certain to tell your insurance company that you will be attending a stand alone outpatient facility as this may impact your benefit. The information listed below shows what your insurance company currently has on file. My signature below acknowledges that I have discussed this information with staff and I understand it is not a guarantee of benefits or insurance coverage for my care. For any reason should my insurance deny, I understand that I am responsible for payment in full. Deductible and Coinsurance payments are an estimate. You may be responsible for more than quoted below. **I also understand any payments are due at the time services are rendered.**

DEDUCTIBLE:_____ **AMOUNT MET:**_____
COINSURANCE: _____
COPAY: _____
VISIT LIMIT: _____ **VISIT REMAINING:**_____
TODAY'S COST:_____ **FOLLOW-UP VISIT COST:** _____

Patient Signature: _____
Parent/Guardian Signature
(if patient is under 18) _____