

Accident Insurance Information:

Date of Injury: _____

Claim Number _____ **Did you complete & return an injury application?** yes no

Claims Adjuster: _____ **Did accident occur while working?** yes no

Insurance Company: _____ **Phone Number:** _____

Mailing Address: _____

Attorney: Name & telephone number _____

Mailing Address: _____

CONSENT TO TREATMENT

I hereby authorize the WPTS, Inc. staff to examine and treat me with physical therapy for the injury I have been referred here for or referred myself to WPTS, Inc.

Patient Name (Printed)

Patient Signature & Date

Parent or Guardian if Patient is a Minor (Printed)

Parent or Guardian Signature & Date

Witness

Date

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO HEALTH PROVIDER

Insurance Company/Companies Name(s) _____ I hereby instruct the above named insurance company/companies to pay by check made out to and mailed directly to WPTS, INC. 173 Grove St., Worcester, MA 01605 for professional or medical expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. *This is a direct assignment of my rights and benefits under this policy.* This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy. I understand that WPTS, Inc. complies with HIPAA and will protect my Protected Health Information (PHI) and will use it as allowable by law in the treatment, billing and collections pertaining to my care until my case is closed and full payment received. The complete HIPAA policy is available in the waiting room and upon request. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney for the purpose of securing payment under this policy of insurance or to any Medical Provider associated with my case to effectively treat me. I also authorize WPTS, Inc. to send a thank you card to my referral source. This authorization is in effect until 90 days from the date the last bill is collected.

HIPPA REGULATIONS A photocopy of this Assignment shall be considered effective and valid as the original. **I HAVE BEEN NOTIFIED OF MY RIGHT TO PRIVACY UNDER THE HIPPA REGULATIONS**

Patient Name (Printed)

Patient Signature & Date

Parent or Guardian if Patient is a Minor (Printed)

Parent or Guardian Signature & Date

Witness

Date

COMMUNICATION: Please list the person(s) you designate to be involved with your treatment & care.

NAME

RELATIONSHIP

CONTACT NUMBER

NAME

RELATIONSHIP

CONTACT NUMBER

Worcester Physical Therapy Services, Inc.

Confidential Medical History

Name: _____ DOB: _____ Age: _____

Please describe your symptoms: _____

Please describe how & when your symptoms began: _____

How often to you experience your symptoms? Constant Frequent Occasional Intermittent
76-100% 51-75% 26-50% 25% or less

Indicate intensity of your **pain at rest**: (None) ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ (Unbearable)

Indicate intensity of **pain with movement**: (None) ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ (Unbearable)

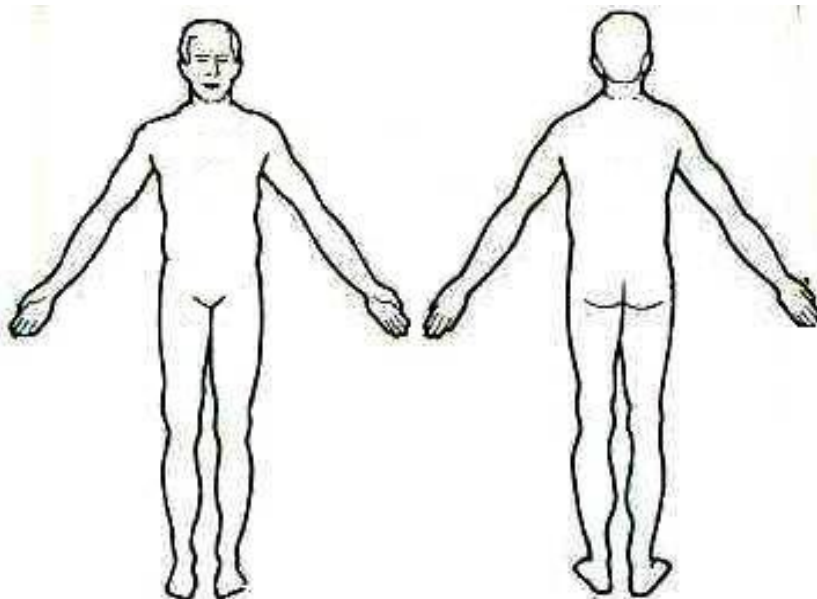
Symptoms are worse in: Morning Afternoon Night Increase during the day Same all day

What makes symptoms better? Nothing Lying down Standing Sitting Movement Inactivity

What makes symptoms worse? Nothing Lying down Standing Sitting Movement Inactivity

Please mark on the pictures where you have pain or other symptoms using the given symbols.

Sharp pain: X Shooting: # Throbbing: ● Burning: △ Dull Ache: ☆ Numbness: ◆



Indicate if you have tried any of these treatments and which, if any, have helped.

✓ Helpful?	Type of Treatment	✓ Helpful?	Type of Treatment
	Physical Therapy		Pain Clinic
	Occupational Therapy		Chiropractor
	Yoga		Acupuncture
	Pilates		Pain Medication:
	Cortisone Injections		Holistic Treatments:
	Other:		I have not been treated for this

Please indicate any of the following conditions that you may have now or had in the past by writing PAST or PRESENT in the blank provided.

	Arthritis		Rheumatoid Arthritis		Lupus
	Fibromyalgia		Epilepsy/Seizure		Diabetes
	Chronic Fatigue		TMJ		Neuropathy
	Edema/Swelling		Asthma		Hepatitis
	Heart Attack		Chronic Headaches		Kidney Disease
	Spinal Stenosis		High Blood Pressure		Abdominal Pain
	Osteoporosis		Heart Disease		Recent weight loss or gain
	Multiple Sclerosis		Pacemaker		Cancer:
	Low Back Pain		Anxiety/Stress		Hernia
	Stroke		Depression		Bone Disease
	Osteoarthritis		Sleep Problem		Thyroid Problem
	Fracture:		HIV/AIDS		Pregnancy

Please indicate any other medical issues (physical, mental or emotional) we should be aware of to best help you:

Do you? Smoke yes no **Drink Alcohol** yes no **Exercise Regularly** yes no

What tests have you had for your symptoms and when were they performed?

X-Ray date: _____ MRI date: _____ CT Scan date: _____

Did you have surgery for this issue? Yes No Date of Surgery _____

When is your next visit to your Primary Care Physician? _____

When is your next visit to your Referring Physician (if other than PCP)? _____

Please list any medications you are currently taking _____

Patient Signature: _____ Today's Date: _____

Worcester Physical Therapy Services, Inc.

PATIENT APPOINTMENT POLICY

We strive to give our patients the utmost professionalism and excellence of service. Our commitment to your well-being is something we take seriously. That's why if your appointed therapist for some unforeseen reason is unable to keep his or her appointment with you, we will do everything in our power to provide a therapist in his or her place to take care of your treatment.

Because we care so much about you, we realize that it would be a disservice to you if we did not emphasize the importance of your own commitment your treatment plan.

Your adherence to the recommended number of treatments is a vital component of your progress; therefore, we have certain rules that need to be followed in order to ensure the most optimum results.

We expect you to keep all your appointments. Please write down the date & times of your future appointments or ask for a printout of your future appointments.

Please read and initial

1. _____ **No-Show:** When a patient is scheduled for an appointment and does not call into cancel nor shows up for the appointment. (Fee will be assessed)
2. _____ **Cancel without 24 Hour Notice:** When a patient is scheduled for an appointment and calls to cancel but does not give 24 hours notice. (Fee will be assessed on a case by case basis)
3. _____ **Cancel with 24 Hour notice or more:** We understand that things can happen, however, we would ask that you do everything in your power to make up your appointments. The make-up appointment needs to be in the same week, preferably the very next day if possible. (No fee see below*)

In an instance of 1 and 2 above, we reserve the right to charge a \$50 fee.

In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care and will inform your physician that your service has been discontinued due to non-compliance with the prescribed treatment plan.

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

Worcester Physical Therapy Services, Inc.

Patient Signature (Guardian Signature if Minor)

Date

Worcester Physical Therapy Services, Inc.
173 Grove Street
Worcester, MA 01605
Tel. 508.791.8740
Fax. 508.752.3716

NOTICE OF HEALTH PROVIDER LIEN

Patient _____ Date of Injury _____
Insurer _____ Attorney _____

I do hereby authorize **Worcester Physical Therapy, Inc.** (Hereinafter referred to as **Provider**) to furnish my attorney with a full report of my examination, diagnosis, treatment, prognosis, etc., in regards to the accident in which I was recently involved.

I hereby authorize and direct my attorney to pay directly to said health provider such sums as may be due and owing him for the medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said health provider. And I hereby further give a Lien on my judgment or verdict which may be paid to my attorney or myself as a result of the injuries for which I have been related or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said health provider for all medical bills submitted by him for services rendered me and that this agreement is made solely for said health provider's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said health provider of any change or addition of attorney(s) used by me in connection with this accident and I instruct my attorney to do the same and to promptly deliver a copy of this Lien to any such substituted attorney(s).

I acknowledge this letter by signing below and returning to the Provider's office. I have been advised that if my attorney does not wish to cooperate in protecting the interest of the Provider that the Provider will not await payment and may declare the entire balance due and payable.

Patient Signature _____
Date

Provider Witness _____
Date

The undersigned, being the attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said Provider. Attorney further agrees that in the event this Lien is litigated, the prevailing party will be awarded attorney fees and costs.

Attorney Signature _____
Date