WORCESTER PHYSICAL THERAPY SERVICES, INC.
PATIENT REGISTRATION

NAME____
First MI Last

Name you prefer us to address you by: ________________________

ADDRESS ____ ______________________________
Street PO Box

ADDRESS____
City State Zip

HOME PHONE _______________ **CELL PHONE**______________ **WORK PHONE** ________________

(Please circle which is the best telephone number to reach you)

DATE OF BIRTH: __________________ ☐ **M** ☐ **F** Marital Status: ☐ M ☐ S ☐ D ☐W ☐ Sep.

SSN: ________________ **E-MAIL:** _______________________________ (only for us to communicate with you)

How did you hear about us? ☐ Dr. ____________________ ☐ Insurance Book/Listing ☐ Yellow Pages

☐ Friend ________________ ☐ Relative _________________ ☐ Other: ______________ ☐ Internet

EMPLOYER

Employer ____ Work Status: ☐ FT ☐ PT ☐ Per Diem

Occupation ____ ☐ Disabled ☐ Retired ☐ Unemployed

PHYSICIAN

Primary Care Physician _________________________________ Office Phone _______________________

Address ____ When were you last seen? _____________
Street City ST Zip

Referring Physician ___________________________________ Office Phone _______________________

Address ____ When were you last seen? _____________
Street City ST Zip

Is treatment due to an accident? ☐ No ☐ Car ☐ Work ☐ Other: ____________ Date of Injury? ______________

Have you had ANY physical therapy before? ☐ yes ☐ no if so, for what & when? ________________________

HEALTH INSURANCE

Insured's Name ________________________________ **Their Date of Birth** ____________________

Your Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: ____________________________

Health Insurance Company: ______________________ **Phone Number:** ______________________

ID Number: ___________________________________ **Group Number:** ______________________

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/records pertinent to my case to or from any insurance company, adjuster or attorney for the purpose of securing payment under this policy of insurance or to or from any Medical Provider associated with my case to effectively treat me and to request any records from a Medical Provider as well. 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 76–100% ☐ Frequent 51-75% ☐ Occasional 26-50% ☐ Intermittent 25% or less

Indicate intensity of your **pain at rest:** (None) ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ (Unbearable)

Indicate intensity of **pain with movement:** (None) ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ (Unbearable)

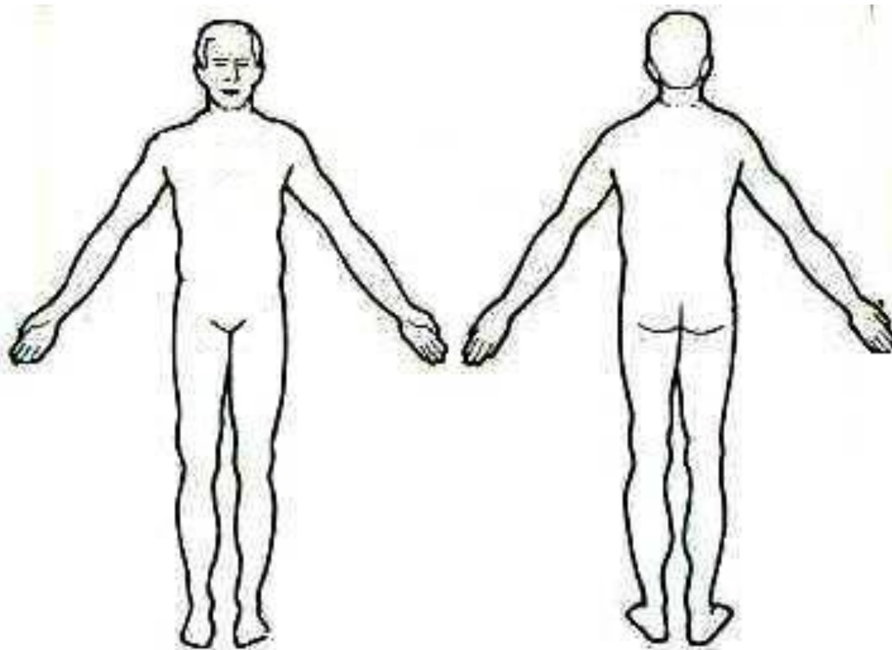
Symptoms are worse in: ☐ Morning ☐ Afternoon ☐ Night ☐ Increase during the day ☐ Same all day

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 **C**are **P**hysician**?** _____________________________________

When is your next visit to your Referring Physician (if other that 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**