



**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)

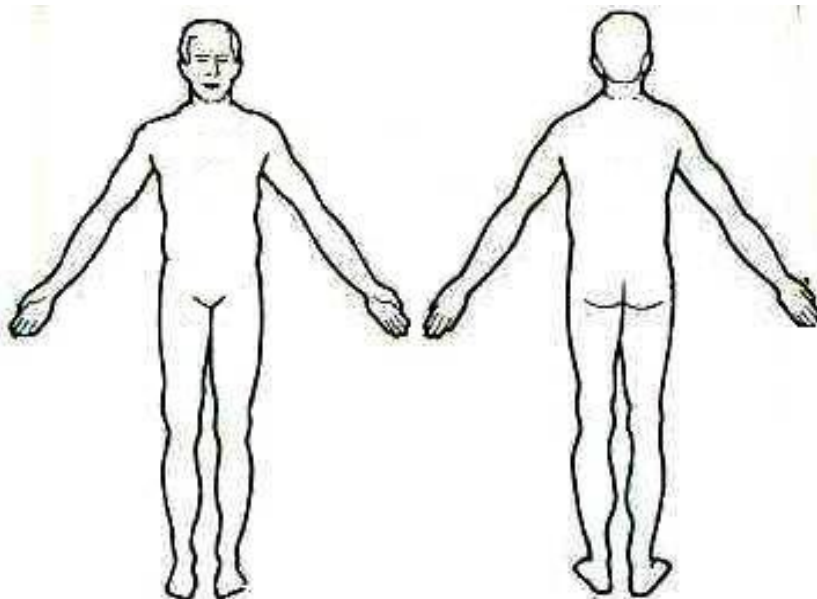
Symptoms are worse in:  Morning  Afternoon  Night  Increase during the day  Same all day

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**

**Secondary Health Insurance Information**

Insured's Date of Birth \_\_\_\_\_

Primary Insured Name \_\_\_\_\_ Relationship to insured \_\_\_\_\_

Health Insurance Company Name \_\_\_\_\_

Address \_\_\_\_\_

Street

City

State

Zip

Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Contact \_\_\_\_\_

Group Number \_\_\_\_\_

ID Number \_\_\_\_\_

**CONSENT TO TREATMENT**

I hereby authorize E. Thomas Willett, PT, and/or his staff to examine and treat me with physical therapy for the injury I have been referred here for or referred myself to at Worcester Physical Therapy, Inc.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Printed Name

\_\_\_\_\_  
Staff Witness Signature

\_\_\_\_\_  
Parent or Guardian Signature if Patient is a Minor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian Printed Name if Patient is a minor

\_\_\_\_\_  
Staff Witness Signature

**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: Worcester Physical Therapy, Inc. 173 Grove Street 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 also agree to pay interest on balance past 90 days. I understand that Worcester Physical Therapy, 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. This authorization is in effect until 90 days from the date the last bill is collected.

**HIPPA REGULATIONS** A photo copy 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)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Parent or Guardian (Printed)

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

*COMMUNICATION:* Please list the family member(s) or other person(s) you designate to be involved with your treatment and care.

\_\_\_\_\_  
NAME

\_\_\_\_\_  
RELATIONSHIP

\_\_\_\_\_  
CONTACT NUMBER

\_\_\_\_\_  
NAME

\_\_\_\_\_  
RELATIONSHIP

\_\_\_\_\_  
CONTACT NUMBER