FYZICAL®
Therapy & Balance Centers

44 Rivulet Street
Uxbridge, Ma 01569
Phone (508) 278-2002
Fax (508) 278-3522

Patient Registration Form

Name:_____ Date of Birth: ___/____/____ SSN: _____

Mailing Address:_____
(PO Box) Street City/Town State Zip Code

Home Phone:_____Cell Phone:_____Work Phone:_____

Primary Phone: □ Home □ Work □ Cell Email: _____@_____.com

Marital Status: □ Single □ Married □ Divorced/Separated □ Other

Occupation:_____ □ F/T □ P/T □ Retired □ Student □ Other:_____

Emergency Contact Name/relationship:_____ Phone:_____

Primary Care Physician:_____ Referring Physician:_____

Primary Health Insurance Co:_____
Subscriber Name, if other than patient:_____

Subscriber Date of Birth: _____/____/_____

Secondary Health Insurance Co: _____

Are your injuries a result of a motor vehicle accident? Yes__ No__ Date ___/___/___

Are your injuries a result of a worker's compensation accident? Yes__ No__ Date ___/___/___

If the answer to either of the above questions is yes, please provide the following information so that we may bill the appropriate company for your physical therapy services.

Ins. Co. Name:_____Adjuster:_____Claim #:_____

Phone:_____Fax:_____Address:_____

Per your insurance, Physical Therapy Services may *NOT* be booked on the same day of other Medical Services.

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Medical History

Name:_____ Age:_____ Sex: M F

How did you hear about us?
Please check all that apply: □ Medical Referral □ Internet Search □ Insurance Co.
□ Facebook □ Newspaper □ Sports sponsorship
□ Other: _____

I give my written consent to be videotaped during my treatment for: □ Therapeutic Use Only
□ I would prefer not to be videotaped □ Promotional Materials

When is your next scheduled follow up appointment with your physician? _____

Have you received X-Rays or MRI related to your injury? Y_____ N___

Have you had any surgeries in the past? Y_____ N___

If yes, please specify: _____

Have you had physical therapy in the past year? Y_____ N___

If yes, please note when and where:_____

Do you have any allergies we should be aware of? Y_____ N___

If yes, please specify: _____

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Payment Information

Thank you for choosing Lomonaco Rehabilitation Services, Inc. to provide your physical therapy needs. The following is some information in regard to the finances of your visit.

Payment Policy
Payment for physical therapy treatment is the responsibility of the patient. You are encouraged to contact your health insurance carrier to find out what your physical therapy benefit, or coverage is, based on your policy. We will verify your benefit as well and file claims on your behalf to your insurer. Should your health insurance coverage expire or terminate while you are still being treated, let us know and further options will be discussed.

Co-payments, Co-insurance, and Deductibles
Our front office will verify your physical therapy insurance benefits prior to your first visit. This will be reviewed with you on your first visit. We require that payments be paid at the time that our services are rendered, unless other arrangements have been made. Co-insurances (typically a percentage of the allowed insurance payment) and deductible responsibility will be estimated at the time of service, and once the explanations of benefits (EOB's) are received, we will review the balance and adjust accordingly. Cash, check and MasterCard/Visa are acceptable forms of payment. There is a $25.00 minimum fee on returned checks.

Please make checks payable to Lomonaco Rehabilitation Services

Cancellations
We acknowledge at times you may be unable to attend your scheduled visits. As a courtesy, please give us at least 24 hours' notice if you need to cancel your visit. This will allow us to provide care to another patient that may be waiting for treatment. There is a $25 fee charged if less than 24 hours' notice is given.
Initial _____

No Shows
For appointments where this is no call/ no show you will be charged a $25 fee. If there are 2 consecutive no call/ no show's your remaining appointments will be removed from the schedule.
Initial _____

Thank you for giving us the opportunity to serve you. Please feel free to ask us any questions about our services, policies and fees.

_____ _____
Print patient name Date

_____
Patient Signature (Parent or Guardian if patient is less than 18 years of age)

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Informed Consent for Physical Therapy Care

I, hereby agree to a physical therapy evaluation and routine treatment by a Massachusetts licensed physical therapist or under his/her supervision, a Massachusetts licensed physical therapy assistant. I understand that the physical therapy treatment will be provided for the identification, prevention, remediation, and rehabilitation of an acute or chronic physical dysfunction. I understand that my physical therapist/physical therapist assistant will have me involved in the decisions of my care at all times. My consent to any treatment set forth is voluntary and I may withdraw any such consent at any time and to any aspect of the prescribed treatment.

Benefits to be expected

Although no assurance can be given and every case is individual, common benefits associated with regular participation in a physical therapy program include, but are not limited to, improvement in joint range of motion/flexibility, muscle strength, body mechanics, decreased pain levels, and reduction in future injury risk with the primary goal to restore maximum functional independence.

Risks and Discomforts

As with any medical procedure or treatment there are risks. These include abnormal blood pressure, fainting, disorders of heart rhythm, excessive perspiration and, in very rare instances, heart attack, stroke or death. Every effort will be made to minimize those risks by the initial examination/evaluation and by observations during the therapy sessions. If you have any concerns or questions about a particular portion of the proposed treatment, please notify your physical therapist or physical therapy assistant and he/she will address these issues.

Your responsibility as a patient

To gain the expected benefits of treatment, you must give priority to regular attendance and adherence to prescribed amounts of intensity, duration, frequency, progression and type of activity and will report any unusual symptom(s) which you may experience before, during, or after a physical therapy treatment session.

Authorization to Release Information/Record Requests

In order to make informed decisions regarding your physical therapy treatments, it is helpful for your physical therapist to have access to your medical records. By initialing the box below, you authorize release of your medical, hospital, or surgical records to Lomonaco Rehabilitation Services, Inc. pertinent to your physical therapy treatment, including but not limited to imaging, exams, surgical reports, special tests, or lab results. In addition, I authorize the release of my physical therapy treatment information to insurance companies or attorneys as needed to facilitate approval or payment, with the exception of the following:

_____

_____

☐ **Please Initial**

I have read, or have had read to me the above consent. By signing below, I agree to, or agree to have my child, receive routine physical therapy treatment as explained to me by the treating physical therapist. My signature also attests to the fact that I have been given the Notice of Privacy Practices and been given ample opportunity to review it. I intend this consent to cover the entire course of treatments for my condition for which I seek treatments from Lomonaco Rehabilitation Services, Inc.

_____ _____

Print patient name Date

_____

Patient Signature (Parent or Guardian if patient is less than 18 years of age)