FLAHERTY
PHYSICAL THERAPY

411 West Main Street, Suite 3
Northborough, MA 01532
p: 508-393-9000 f: 508-393-9525
e: info@flahertyphysicaltherapy.com
w: www.flahertyphysicaltherapy.com

CONSENT FOR TREATMENT 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 therapy assistant will have me involved at all times in the decisions of my care. 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. I agree, or agree to have my child, receive routine physical therapy treatment as explained to me by the treating physical therapist.

Initials _____ Date _____

HIPAA REGULATIONS I understand that Flaherty Physical Therapy complies with HIPAA and will protect my Protected Health Information (PHI). I understand my information will be used as allowable by law in the treatment, billing and collection pertaining to my care until my case is closed and full payment is received. I also authorize the release of any information pertinent to my case to my insurance company, adjuster, attorney, or medical provider for purpose of securing payment. This authorization remains in effect until 90 days from the date of the last bill collected.

Initials _____ Date _____

FINANCIAL RESPONSIBILITY Payment for physical therapy treatment is ultimately the responsibility of the patient. For those who have health insurance, we will file claims on your behalf. Should your health insurance coverage expire or terminate while you are still being treated, let us know and further options will be discussed. For Workers Compensation cases, we will bill third-party payers. The patient will be responsible for any collection costs, should the use of a collection agency be required to receive payment on your account. Our front office will verify your physical therapy insurance benefit prior to your first visit. This will be reviewed with you on your first visit. **WE REQUIRE THAT PAYMENTS BE PAID AT THE TIME OUR SERVICES ARE RENDERED**. Cash, check and credit cards are acceptable forms of payment. There is a $20.00 minimum fee on returned checks.

CREDIT CARD ON FILE AGREEMENT I understand that Flaherty Physical Therapy, Inc is utilizing the latest standards in card data security and HIPAA compliance. Card data stored is encrypted and tokenized and stored off-site in a secure vault trusted by many Fortune 500 companies. I understand that Flaherty Physical Therapy, Inc will automatically debit the card on file for any outstanding patient responsibility, including standard co-pays, remaining balance, payment plans and no-show fees. I understand that I can update my card information on file at any time by contacting our office directly. In fact, it is my responsibility to notify Flaherty Physical Therapy, Inc of any updates or changes to the credit card on file associated with this agreement as soon as possible.

Initials _____ Date _____

OTHER WAYS WE WILL CONTACT YOU We also use or disclose your PHI for purposes that involve your relationship to us as a patient. We may use or disclose your PHI to: remind you of your scheduled appointments; carry out follow ups on your home programs you have been taught; carry out follow ups on discharge planning; advise you of new or updated services or home supplies via telecommunication or via a newsletter (you can choose to opt-out of receiving information of this nature from us); carry out marketing functions such as providing nominal promotional gifts (you can choose to opt-out of receiving any marketing information or items from us); contact you regarding fundraising projects that we are engaged in (you can choose to opt-out of any fundraising project notification that we engage in).

Initials _____ Date _____

I have read or have had read to me the above consent. By signing below, I agree, or agree to have my child, receive routine physical therapy treatment as explained to me by the treating physical therapist. I hereby assign payment of benefits by my insurance company to Flaherty Physical Therapy and accept responsibility to ensure my insurance carrier makes payment on my account within 90 days due and payable unless other financial arrangements have been made. I intend this consent to cover the entire course of treatments for my condition for which I seek treatments from Flaherty Physical Therapy, Inc.

Patient _____ Signature _____ Date _____

Parent/Guardian _____ Signature _____ Date _____

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MEDICAL HISTORY FOR PHYSICAL THERAPY CARE

Name: _____ Age: _____ Sex: ❑ M ❑ F

What is the date of your next physician visit? _____

Have you received any X-rays or MRI related to your injury? ❑ Yes ❑ No

Have you had any surgeries in the past? ❑ Yes ❑ No

If yes, please specify: _____

Have you had physical therapy in the past year? ❑ Yes ❑ No

If yes, please note where and when: _____

Do you have any current allergies we should be aware of? ❑ Yes ❑ No

If yes, please specify: _____

Please answer yes or no to the following:

Medical History	Yes	No	Medical History	Yes	No
Anxiety/Depression			Heart Attack/Surgery		
Asthma/Hay Fever			Immune Deficiency/Disease		
Arthritis			Joint Replacement Surgery		
Back injury or pain			Kidney Disease		
Neck Injury of pain			Liver Disease/Hepatitis		
Cancer/Tumor			Lung Disease/Tuberculosis		
Chest Pain			Osteoporosis		
Clotting/Bleeding Disorder			Neurological Disease/Stroke		
Convulsions/Epilepsy			Pace Maker/Defibrillator		
Diabetes			Skin Disorders/Psoriasis		
Eye Issues/Glaucoma/Cataract			Thyroid Disease		
Fractures			Vertigo/Vestibular Issues		
High Blood Pressure			OTHER:		
Do you smoke?					

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What makes the pain/symptoms increase? ❑ Work ❑ Sports ❑ Standing ❑ Sitting

❑ Other: _____

What makes the pain/symptoms decrease? ❑ Rest ❑ Heat ❑ Medications ❑ Standing ❑ Sitting
❑ Lying Down ❑ Sleeping ❑ Ice ❑ Exercise

❑ Other: _____

How often do you have your symptoms? ❑ Constantly ❑ Occasionally ❑ Rarely

❑ Only when I _____

Are your symptoms? ❑ Improving ❑ Worsening ❑ Staying the same

Current Limitations with Functional activities:
Because of my current complaint I am having difficulty (fill in on the line below)

_____

What would your rate your pain/symptoms:

At worst:

0 1 2 3 4 5 6 7 8 9 10
No pain Minor Moderate Severe Worst pain ever

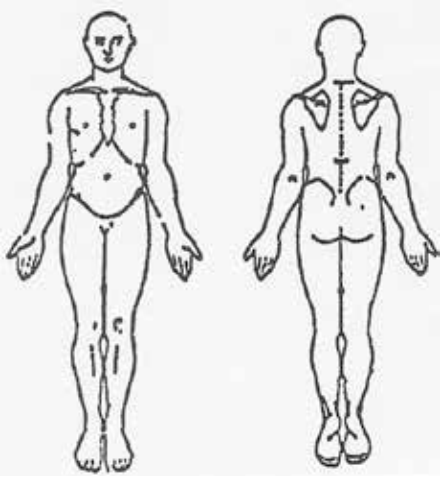
At best:

0 1 2 3 4 5 6 7 8 9 10
No pain Minor Moderate Severe Worst pain ever

Currently:

0 1 2 3 4 5 6 7 8 9 10
No pain Minor Moderate Severe Worst pain ever

Pain Diagram
Please shade areas of pain below



What are your current goals for physical therapy?

_____

What is your current exercise regime like now?

_____

Who can we thank for referring you to Flaherty Physical Therapy? _____

Have you seen any promotional information about Flaherty PT? ❑ Yes ❑ No

Where did you see it? _____

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CURRENT MEDICATION FORM

Patient Name: _____ Date:_____

Please list all prescription medication, over the counter medication, herbals, or vitamin/dietary supplements you are presently taking.

Medication Name	Dosage	Frequency [Circle which applies]	Route [Circle which applies]
		Once a day / Twice a day / Other:	Oral / Injection
		Once a day / Twice a day / Other:	Oral / Injection
		Once a day / Twice a day / Other:	Oral / Injection
		Once a day / Twice a day / Other:	Oral / Injection
		Once a day / Twice a day / Other:	Oral / Injection
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FLAHERTY PHYSICAL THERAPY
ATTENDANCE POLICY

Because we want you to have the most successful rehab experience possible, we would like to stress the IMPORTANCE of your attendance to all of your scheduled appointments.

Your success depends on your COMMITMENT. Please make physical therapy your priority over the next few weeks. Remember, you are only being asked to come for about 1-3 hours each week. Due to that, you need to be as consistent as you can so you can get the best outcome from your rehab. Your therapist will give you a recommended treatment plan. You need to keep all of your appointments with the exception of a serious emergency. In instances of repeated “no shows” or last minute cancellations we reserve the right to discontinue your treatment. We will inform your physician that you were not compliant with the prescribed PT order and suggest that you wait until you can commit more time to your therapy.

******If you absolutely cannot make your scheduled appointment******

We kindly ask for a phone call with at least 48 HOURS notice. We will work with you to reschedule your appointment for another time later that week so that way you will not miss your PT session.

If your appointment is LESS than 48 HOURS, we will make every attempt to fill your spot with another patient. However, we reserve the right to charge you $20 if we are not able to fill it.

If NO CALL is made to cancel your appointment, we will charge you our “No show” fee of $20 which must be paid at the time of your next visit. This fee cannot be billed to your insurance company.

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

I understand and agree to adhere to the Flaherty Physical Therapy attendance policy.

Patient Signature: _____ Date: _____

LET’S MOVE!