

McGovern Physical Therapy Associates

350 Main Street, 1st Floor Malden, MA 02148 phone: (781) 321-2727 fax: (781) 321-4995

How did you find out about us? oDoctor oNewspaper oPhonebook oFriend (name)_____

oWebsite oSign oProfessional Contact (name)_____ Radio Attorney (name)_____

What about the above made you call us today? _____

PATIENT INFORMATION

Last Name: _____ First _____ Middle _____

Address: _____

Street City State Zip Code

Home Phone: _____ Work: _____ Cell: _____

E-Mail Address: _____

Date of birth: ____/____/____ Sex: Male Female Social security # _____

Employer: _____

Name Street City State Zip Code

Emergency Contact Name: _____ Telephone number: _____

HEALTH INSURANCE

Health Insurance Carrier Name: _____

Health Insurer Address: _____

Street City State Zip Code Phone Number

Name of Insured: _____ Relationship to Insured: _____

Patient ID Number: _____

Primary Care Physician: _____

Name Town Phone Number

Have you obtained a referral yes no **Obtaining a referral is the sole responsibility of the patient.**

AUTO INSURANCE

Date of injury: ____/____/____ Attorney Name: _____

Claim Number: _____ Phone Number: _____

Auto Insurance Carrier Name: _____

Auto Insurer Address: _____

Street City State Zip Code

Adjuster Name: _____ Phone Number: _____

WORKERS COMPENSATION

Date of injury: ____/____/____ Attorney Name: _____

Claim Number: _____ Phone Number: _____

Insurance Carrier Name: _____

Insurer Address: _____

Street City State Zip Code

Adjuster Name: _____ Phone Number: _____

The above information is true to the best of my knowledge. I understand that my insurance may not pay all of my bills and I may be responsible for payment, co-pays, deductibles or co-insurance.

Patient Signature: _____ Date: ____/____/____

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INFORMED CONSENT FOR TREATMENT

I hereby voluntarily and of free will give consent and permission to **McGovern Physical Therapy Associates** to administer physical therapy services. I am aware that a physician may refer me to physical therapy or I may seek one out on my own because of Direct Access in the Commonwealth of Massachusetts. I understand that I will be evaluated by a licensed physical therapist. A physical therapist, physical therapy assistant, or a rehab aid may conduct all treatment. All assistants will work under the supervision of the physical therapist. I understand the nature of my condition, that certain risk may be involved, and that there are no guarantees for treatment success. In the event of a change in medical status, I understand that my treatment may be modified or stopped. I reserve the right to withdraw my consent at any time.

SIGNATURE: _____

RELEASE OF MEDICAL INFORMATION

I hereby authorize **McGovern Physical Therapy Associates** to obtain any and all medical records needed to aid my evaluation and treatment in physical therapy. I further give consent to release any medical information and bills to necessary third parties for the purpose of review, case record, and payment.

SIGNATURE: _____

Cancellation and No-Show Policy

Cancellation: an unfulfilled appointment where the patient calls the office to notify the staff ahead of time

No-show: an unfulfilled appointment where the patient fails to notify the office and staff ahead of time

MPTA books specific slots of time for you and for all of our patients allowing everyone to receive the utmost personal care and attention. Late cancellations and no-shows greatly impair our ability to provide the best care possible to our patients, slows each patient's rehabilitation progress and eliminates a treatment appointment that could have been used by another patient. **MPTA requires patients to allow a courtesy of 24 hours notification for all cancellations. MPTA reserves the right to charge you \$50.00 for a cancellation within 2 hours prior to your scheduled appointment time. MPTA reserves the right to charge you \$85.00 for all no-show appointments, as well as removing all future scheduled appointments and discharging you from our care.** MPTA requests that you adhere to this policy so that we may offer readily available appointments for you and for all of our patients.

I HEREBY AGREE TO, AND WILL UPHOLD, THE POLICY STATED ABOVE.

Signature: _____

ASSIGNMENT OF BENEFITS AND PAYMENT TO McGovern Physical Therapy Associates

1. I hereby **authorize direct payment to McGovern Physical Therapy Associates**, by my insurance company for services rendered, and/or by my attorney out of any settlement for my services rendered.
2. In the event that any Insurance Company obligated to make payment to **McGovern Physical Therapy Associates** for services rendered, refuses to make such payment upon demand, **I hereby assign and transfer to McGovern Physical Therapy Associates the cause of action that exists in my favor against any such company and authorize McGovern Physical Therapy Associates to pursue said action in my name or your name as you see fit.** I understand that whatever sums are not collected, I am responsible for payment.

PATIENT SIGNATURE: _____

PATIENT PRINTED NAME: _____

WITNESS SIGNATURE: _____

-----**FOR OFFICE USE ONLY**-----

INSURANCE CONSENT AND POLICY

1. Under the terms of your insurance plan you are required to pay _____% or \$ _____ as a co-pay with each visit. Co-Pays are due at each visit. Your deductible is \$ _____.
2. You are required to have a current referral for each visit. o yes o no
3. You have a maximum year benefit of \$ _____ or _____ visits and/or _____ consecutive days from the start of care. Once these benefits have exhausted further care would have to be paid by you. We have cash rates available. We accept cash, check or charge for any expenses occurred.

I the undersigned have been read and explained the financial arrangements of my care at McGovern Physical Therapy Associates.

PATIENT SIGNATURE: _____ **EMPLOYEE SIGNATURE** _____