

McGovern Physical Therapy Associates

385 Broadway, Suite 205, Revere, MA (781) 485-1001 Fax (781) 485-1003

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.**

**Patient 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** \_\_\_\_\_