WORCESTER PHYSICAL THERAPY 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 you're 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 are 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 & time 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 in to 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 appreciated 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**

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
_____	_____	_____
Please print Parent/Guardian Name if Patient is a minor.	Parent/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. 30 Glennie 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 right and benefits under this policy and is irrevocable***. 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/records pertinent to my case to or from any Medical Provider associated with my case to effectively treat me and to request any records from a Medical Provider as well. I authorize WPTS, Inc. to send a thank you card to the referral source. This authorization is in effect until 90 days from the date the last bill is collected. **HIPAA 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 HIPAA REGULATIONS.**

_____	_____	_____
Patient Name (printed)	Patient Signature	Date
_____	_____	_____
Please print Parent/Guardian Name if Patient is a minor.	Parent/Guardian Signature	Date

Witness_____ Date_____

COMMUNICATION: Please list the person(s) you designate to be involved with your treatment and care,

_____	_____	_____
Name	Relationship	Contact Phone Number
_____	_____	_____
Name	Relationship	Contact Phone Number

Worcester Physical Therapy Services, Inc.

Confidential Medical History

Name: _____DOB:_____Age:_____

Height: _____ **Weight: _____**

Have you had any falls in the past 12 months? ☐No ☐Yes

Please describe your symptoms: _____

Please describe your symptoms and when they began: _____

_____

How often do you experience your symptoms? ☐Constant ☐Frequent ☐Occasional ☐Intermittent
76-100% 51-75% 26-50% 25% or less

Indicate intensity of your **pain at best:** (None) ○○○○○○○○○○○ (Unbearable)

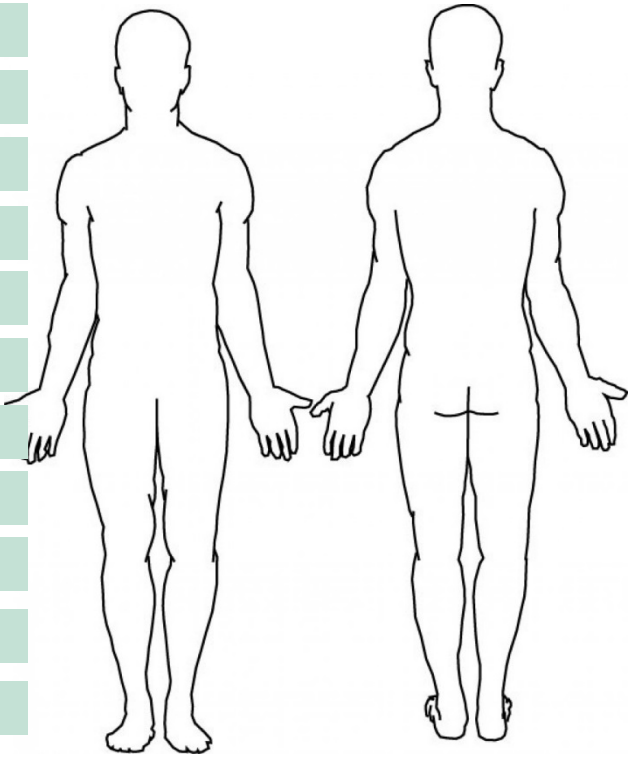
Indicate intensity of **pain at worst:** (None) ○○○○○○○○○○○ (Unbearable)

Indicate your **current pain**: (None) ○○○○○○○○○○○ (Unbearable)

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: ♦

# -throbbing		n/a
n/a		DA -dull ache
n/a		n/a
n/a		n/a
n/a		B -burning
n/a		n/a
n/a		n/a
n/a		n/a
n/a		n/a
n/a		n/a
n/a		n/a

Worcester Physical Therapy Services, Inc.

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 Treatment:
		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 blanks provided.

	Arthritis		Rheumatoid Arthritis		Lupus
	Fibromyalgia		Epilepsy/Seizure		Diabetes Type 1 or Type 2
	Chronic Fatigue		TMJ		Neuropathy
	Edema/Swelling		Asthma		Hepatitis
	Spinal Stenosis		Chronic Headaches		Kidney Disease
	Osteoporosis		High Blood Pressure		Abdominal Pain
	Multiple Sclerosis		Heart Disease		Recent weight loss/gain
	Low Back Pain		Pacemaker		Cancer:
	Heart Attack		HIV/AIDS		Hernia
	Stroke		Anxiety/Stress		Bone Disease
	Osteoarthritis		Depression		Thyroid Problem
	Fracture:		Sleep Problem		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 or please provide a list:

_____

Patient Signature: _____ Date:_____