Berkshire Physical Therapy & Wellness

740 Williams Street
Pittsfield, MA 01201
(413)447-8070

400 Main Street
Dalton, MA 01226
(413)684-9783

480 Pleasant Street
Lee, MA 01238
(413)243-3477

NAME: (Last) _______________ (First)_____________________ DOB: _____/_____/_____ Male / Female

ADDRESS: __________________________ CITY: _____________________ STATE: _____ ZIP: __________

(Home #)_________________ (Work #)_______________ (Cell #)________________ Email: __________________

Out of Town Address (if applicable): ____

SS# _____________________________ Referred by: Doctor / Friend / Family Other:_______________________

EMPLOYER: ____ (PH)_____________________

EMERGENCY CONTACT: ________________________RELATIONSHIP: ____________ PH: ______________

REFERRING PHYSICIAN: _____________________ PRIMARY PHYSICIAN:____________________________

- ★ Please inform your therapist of any pre-existing medical conditions. All information will be confidential.
- ★ If you FAIL to keep your scheduled appointment or do not cancel within 24 hours, we reserve the right to charge the patient $65.
- ★ Have you received any other physical therapy this year? _____ YES _____ NO
- ★ Have you ever received any home health services, ex. Visiting Nurse ? _____ YES _____ NO

PLEASE READ AND SIGN THE AUTHORIZATION BELOW:

Our office is committed to providing you with the best possible care. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered. We make every effort to provide you with accurate coverage/co-pay information however, we are not responsible for mis-information given by your insurance company. Therefore it is your responsibility to have full knowledge of your specific benefits.

I agree to pay my co-payments (if any) as services are rendered.
My policy has a co-payment of $___________ per visit which is due at the time of each visit.
My policy has a deductible of $___________ and __________% co-insurance. If for any reason a balance is outstanding on my account, I agree to pay promptly upon receipt of statement. There will be a $15 fee for returned checks.

I understand that it is my responsibility to be fully knowledgeable of my insurance benefits. It is also my responsibility to inform Berkshire Physical Therapy & Wellness as soon as possible of any changes to my insurance coverage during my course of physical therapy. Failure to do so may result in additional financial responsibility, owed by me, due to insurance denials based upon claims that are not filed in a timely fashion or filed with inaccurate data.

I authorize Berkshire Physical Therapy & Wellness to release such information as required by my attorney and/or insurance company to secure my insurance benefits. I understand I will be responsible for services not covered by my insurance company and failure to supply necessary referrals, or prescriptions to secure payment of my account. Payment to Berkshire Physical Therapy & Wellness is not contingent on settlement. A photocopy of this authorization shall be valid as original.

SIGNATURE: _____________________________________ DATE: __________________________

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MEDICAL HISTORY

NAME: ____ DATE: __________________

1. HAVE YOU EVER HAD ANY OF THE FOLLOWING PROBLEMS?

_____ DIABETES
_____ NERVE/NEUROLOGICAL
_____ CARDIAC/HEART/PACEMAKER
_____ CIRCULATORY VASCULAR (CLOTS/PHLEBITIS)
_____ CANCER/TUMOR
_____ PARKINSON'S
_____ HIGH BLOOD PRESSURE
_____ ALLERGIES
_____ ARTHRITIS
_____ JOINT REPLACEMENT
_____ FRACTURES
_____ STROKES
_____ ASTHMA
_____ BACK/NECK INJURY
_____ SEIZURES
_____ EAR/NOSE/THROAT
_____ SWALLOWING
_____ COUGHING
_____ VISION
_____ SPEECH/LANGUAGE
_____ MEMORY
_____ HEARING
_____ OTHER

COMMENTS: ____

2. DO YOU PRESENTLY HAVE ANY OF THE FOLLOWING CONDITIONS: PREGNANCY, HEPATITIS, TB, CONTAGIOUS OR INFECTIONS DISEASE? _____ YES _____ NO

3. WHAT IS THE CONDITION FOR WHICH YOUR DOCTOR REFERRED YOU TO THERAPY? _________

____

4. ARE YOU CURRENTLY RECEIVING ANY OTHER TREATMENT FOR THIS CONDITION? ________

____

5. LIST ANY RECENT HOSPITALIZATIONS & REASON: _______________________________________

6. LIST ANY RECENT TESTS PERTAINING TO CURRENT PROBLEM (X-RAYS, MRI, ETC.) __________

____

7. LIST MEDICATIONS & DOSAGES YOU ARE CURRENTLY TAKING: ____________________________

____

8. HAVE YOU EVER HAD THERAPY IN THE PAST: ____

9. HAS YOUR DOCTOR IMPOSED ANY RESTRICTIONS ON YOUR ACTIVITIES? ___________________

____

10. WHAT ARE YOUR GOALS AND EXPECTATIONS OF TREATMENT? ___________________________

____

SIGNATURE: ____

NOTICE AND ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

1. Patient Consent To Treat
   I, the undersigned patient, consent to such treatment procedures as are deemed necessary by the provider, including those which are in addition to or different from those initially contemplated, and which are deemed necessary or advisable by the provider in the course of treatment.

2. Patient Consent for Use and Disclosure of Protected Health Information (PHI)
   I, the undersigned patient, give my consent to the provider entity and its agents to use or disclose my protected health information (PHI) to carry out treatment, payment, or health care operations. These individuals and entities can release, use or disclose my PHI to other health care personnel including, but not limited to, physicians, certified registered nurse anesthetists, anesthesia assistants, nursing staff, nurse practitioners, physician assistants, child life specialists, physical therapists, respiratory therapists, X-ray personnel, audiologists, students in each of the above disciplines, and other such entities or persons as are deemed related to treatment, or payment, and health care operations, as determined in the sole discretion of the provider, his/her practice group, and their respective agents.

3. Permission to Release Medical Records to Providers
   If another provider who is involved with my treatment, payment, or health care operations relating to me requests my medical records, I consent to the release of my entire medical record maintained by the provider to those other providers.

4. Permission to Release Billing Information Over the Telephone
   I agree, as part of this consent for payment operation, that the provider, its group, and their billing personnel, billing agents, or management company can disclose billing information to any person who calls the provider with a billing question after the provider inquires as to the identity of the calling person and the calling person provides my correct social security number or health plan number.

5. Permission to Call and Leave Voice Mail Messages
   I agree that the provider or its agents or representatives may call and leave a voice mail message at my home or other number I provide them regarding medical appointments, billing or payment issues, or other information related to treatment, payment or health care operations.

6. Permission to Discuss Protected Health Information With Third Persons
   I agree that the provider may discuss my PHI with any person who accompanies me to a visit or procedure or is present with me when the provider is present. The provider may rightly assume that if another person is with me, I have no objection to disclosure of my PHI to that person. I also agree that the provider may discuss my PHI with any person who identifies him or herself as active in my mental, physical, emotional, or spiritual care, including, but not limited to family, friends, clergy, and patient advocates. I also agree that the provider, his/her practice group, and their agents may disclose my PHI to employers who arrange and pay, directly or indirectly, for my medical treatment.

7. Permission to Discuss Protected Health Information Regarding Minors
   I agree that the provider, his/her practice group, and their agents may discuss my child's PHI with the person accompanying the child. I agree that the provider may discuss PHI with both natural parents and stepparents. I acknowledge that state law may grant my child certain privacy rights regarding the child's PHI, and that I have no right to receive this information.

8. Permission to Discuss Protected Health Information With Public Agencies
   I agree the provider, his/her practice group, and their agents may, upon request by the following entities, disclose my PHI to public health agencies, law enforcement, and the FDA.

9. Acknowledgment of Receipt of Notice of Privacy Practices
   I acknowledge that I have received this Notice of Privacy Practices which sets forth this provider's privacy practices and my rights regarding privacy of my PHI.

___________________________________ _______________________

Patient Signature Date

____

Print Name