PHYSICAL THERAPY U
LEARN REHAB RECOVER

NAME_____DATE OF BIRTH_____

OCCUPATION_____EMPLOYER_____

WORK ADDRESS_____CITY_____STATE_____ZIP_____

E-MAIL ADDRESS_____PRIMARY PHONE #_____

HOW DID YOU HEAR ABOUT US?_____

IN CASE OF EMERGENCY CONTACT:

NAME_____ PHONE NUMBER_____

RELATIONSHIP_____ (IF THIS PERSON IS NOT LOCAL, PLEASE LIST AN ADDITIONAL LOCAL CONTACT)

1. **Consent for Treatment**

I, the undersigned, a patient at Physical Therapy U, Inc. (PTU), do hereby authorized the licensed physical therapy staff to administer treatment as they deem necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained.
I understand and agree that health and/or accident insurance policies are an arrangement between the insurance carrier(s) and me. Furthermore, I understand that Physical Therapy U, Inc. will prepare insurance forms, and will bill, only as a courtesy, my insurance company directly. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

2. **Patient Referral and Benefit**

All patients are responsible for contacting their insurance company to find out if they need a referral or authorizations in order for their PT treatment to be covered. In the case that the patient fails to obtain the necessary authorization the patient will be responsible for payment.

It is the patient's responsibility to contact their insurance company to inquire about the out of pocket expenses the patient might incur due to PT treatment. **The amount quoted by the staff at Physical Therapy U is just an estimate based on the type of insurance plan, not a guarantee of benefits**. The patient must call their insurance company to see if a copayment or deductible apply. Any out of pocket expenses incurred, based on your insurance contract, will be the responsibility of the patient regardless of whether they were aware of the cost prior to treatment.

Some plans have co-payments, co-insurance or deductibles, while others have a combination of these. There are also restrictions on the number of visits permitted by the various plans. It is your responsibility to understand the requirements of your particular plan. We will work with you to clarify any questions that we are able.

Any visits that are not covered under your insurance plan will be billed to you at our "payment at time of service" fee of $125 for an evaluation and $80 for a follow up visit.

If the insurance requires a patient to pay a large sum out of pocket and they are having trouble understanding their balance, the patient can contact our office and we will be happy to go over the expenses with you. If the patient is unable to pay their balance in full we will be happy to work out a payment plan.

3. **Authorization to Release Information & E-Communication**

I hereby authorize the release of any information by telephone or in writing, including reports of diagnosis, treatment, prognosis, recommendations, benefits payable, and any other data pertinent to my treatment, by Physical Therapy U, Inc. to my physician(s) as well as any organization responsible for payment of my account. I

authorize my 3rd party payer company to pay medical benefits directly to Physical Therapy U, Inc. in instances where a claim has been filed by Physical Therapy U, Inc. on my behalf.
I hereby consent to have my physical therapist from Physical Therapy U, Inc. communicate via email, fax or phone with me, my referring physician and my insurance company regarding the following aspects of my medical care: appointments, progression or status of treatment, new or changing symptoms, determination of readiness to return to work, prescriptions, authorization or billing. I understand that email is not a guaranteed confidential method of communication. I further understand that there is a risk that email communications between my physical therapists and me or my referring doctor may be intercepted by third parties or transmitted to unintended parties. I also understand that any email communications between my physical therapist and me or my referring physician regarding my diagnosis or medical care will be made a part of my medical record. I understand that in an urgent or timely situation, or for any scheduling needs, I should call Physical Therapy U, Inc. and not rely on email.

Preferred method of communication:

Phone- call/ text ( ) _____

Email ( ) _____

I authorize my therapist to communicate on my behalf with my medical providers for the benefit of my overall success.

4. Cancellation/No-Show Policy

Please note that once you have booked an appointment with us it means that we have reserved time in our schedule for you.
If you cancel your appointment less than 24 hours before it is scheduled to take place, you will be subject to a fee of $50.

To avoid a cancellation fee, please provide cancellation notice at least **24 hours** prior to your appointment.
You can cancel or reschedule an appointment by emailing us at ptuclinic@gmail.com or calling our clinic at 508-697-2000.

I HEREBY AUTHORIZE PAYMENT TO BE MADE DIRECTLY TO **Physical Therapy U, Inc.**, FOR SERVICES RENDERED. I HEREBY AUTHORIZE **Physical Therapy U, Inc.** TO RELEASE (OR OBTAIN) INFORMATION REGARDING MY PHYSICAL THERAPY EVALUATION AND TREATMENT AND RELATING BILLING INFORMATION TO (FROM) MY ATTORNEY AND/OR INSURANCE CARRIER FOR PURPOSES OF PROCESSING THIS CLAIM.

I was offered a copy of Physical Therapy U, Inc. Notice of Privacy Practices. ___ Accepted ___ Declined.

By signing below, you are indicating that you have read, understand, and agree to the terms above.

Patient or Patient's Guardian Signature:

_____ Date:_____

Print:
_____ Date_____

Relationship to patient: _____

COVID-19 Policy Changes and Waiver

I agree to wash my hands or use hand sanitizer upon entering and leaving Physical Therapy U, Inc.
I agree to wear a face mask while in the clinic when requested.
I have not been in contact with anyone with Covid-19 or suspected Covid-19 in the past 14 days OR I have been vaccinated.
I have not been diagnosed with Covid-19 or suspected Covid-19 within the last 14 days.
I agree to have my temperature taken with a no-touch forehead monitor upon entering clinic if asked.
I understand that Physical Therapy U, Inc and its employees reserve the right to refuse treatment if there is any concern to patients or employees at any time for any reason.
I understand that at any point I can request transitioning from in-person visits to Telehealth visits.
I understand guests are not allowed to attend PT with me or wait in the waiting room unless medically necessary.

I understand that Physical Therapy U, Inc. is doing everything in its power to protect employees and patients from transmission or contraction of Covid-19 however there are many unknown factors with viruses and my 100% protection cannot be guaranteed by Physical Therapy U, Inc.

COVID-19 Travel Form

PTU recommends all patients and guests follow CDC travel guidelines. Please review local and CDC travel guidelines if you plan to travel while a patient/client at PTU. If you would like to arrange a telehealth visit during your quarantine phase we can easily accommodate that for you, please let the front desk know PRIOR to said visit.

Patient Signature:_____

Guardian Signature (if under 18):_____

Date:_____

PT U PHYSICAL THERAPY U
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MEDICAL HISTORY FORM

Name:_____ Date of Birth:_____

(For Medicare Patients only) Height_____ Weight_____

Pronoun: __ she/her/hers. __ he/him/his. __they, them, theirs.

Why are you seeing the physical therapist? _____

Location of injury/surgery if applicable: Right_____ Left_____

Current problem is a result of (Check all that apply):

Surgery_____ Injury_____ Work Accident_____ Car Accident_____

Other_____

Rate your pain: Best (0-10) _____ Worst (0-10) _____

Do you have, or have you ever had, any of the following (Check all that apply):

___Asthma, Bronchitis, Emphysema, COPD
___Shortness of Breath
___Chest Pain or Angina
___Coronary Heart Disease
___Pacemaker and/or Defibrillator
___High Blood Pressure
___Heart Attack/Heart Surgery
___Blood Clot/Emboli
___Stroke/TIA
___Allergies/Latex Allergy/Sensitivity
___Pin/Metal Implants- Where?_____
___Joint Replacement- Where?_____
___Diabetes
___Infectious Diseases- What?_____
___Cancer/Chemotherapy/Radiation- Where/Type_____
___Arthritis/Swollen Joints
___Vision or Hearing difficulty
___Numbness or Tingling
___Dizziness or Fainting
___Osteoporosis
___Weight Loss/Energy Loss
___Hernia
___Epilepsy/Seizures
___Thyroid Trouble/Goiter
___Incontinence (Bowel/Bladder Problems)
___Neck/Back Surgery/Injury
___Multiple Sclerosis
___Parkinson's Disease
___Pregnant
___Complicated Pregnancies/Deliveries
___Current Smoker
___Do you exercise?
___COVID-19: if yes, please indicate when and any associated complications due to COVID-19_____
_____

Please list any medications you are currently taking (PTU will take a copy of a list if you have one instead):

_____

_____

_____

Patient or Patient's Guardian Signature:

_____Date:_____