Massabesic Health Resources, P.A.
Physical Therapy & Fitness Center
Therapeutic Pool

392 Main Street
Waterboro, ME 04087
(207) 247-3216

481 Main St
Springvale, ME 04083
(207) 490-4920

PATIENT INFORMATION			**EMAIL ADDRESS:**
First Name:	Last Name:	Middle Initial:	Date: / /
Address:	City:	State:	Zip:
Birth Date: / /	Age:	☐ Male ☐ Female	S.S. #: - -
Home Phone: ( ) -	Alternative Phone (Cell, Pager): ( ) -	Spouse:	
Chose Clinic Because/ Referred to Clinic By ☐ Dr.:	☐ Insurance Plan ☐ Family ☐ Friend		
☐ Former Patient ☐ Close to Work/Home ☐ Website ☐ Yellow Pages ☐ Street Sign ☐ Other:			
IN CASE OF EMERGENCY			
Name of Local Friend or Relative (Not Living at Same Address):			
Relationship to Patient:	Home Phone: ( ) -	Work Phone: ( ) -	
WORK INFORMATION			
Employer:	Work Phone ( ) -	Ext.	
Occupation:	Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed		
HEALTHCARE PROVIDER INFORMATION			
Referring Dr:	Referring Dr. Phone: ( ) -		
Regular Dr./PCP	Regular Dr./PCP Phone: ( ) -		
INSURANCE INFORMATION	**(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)**		
Primary Insurance Name:			
Subscriber's Name (If different):	Birth Date: / /		
ID. #:	Group/Policy #		
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:			
Name of Secondary Insurance:			
Subscriber's Name:	Birth Date: / /		
ID. #:	Group/Policy #		
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:			
AUTO OR WORK INJURY CLAIM	**(PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)**		
Insurance Name: ☐ Auto:	☐ Labor & Industries:		
Adjuster/Claim Manager:	Phone:	Ext.:	
Address:	City	State:	Zip:
Claim #:	Accident Date: / /	Cause:	
INSURANCE AUTHORIZATION			

I authorize my insurance benefits be paid directly to Massabesic Health Resources, P.A. I understand that Massabesic Health Resources, P.A. only bills a secondary insurance when it is a subsequent plan to Medicare or a Medicare replacement plan. I understand that I am financially responsible for any balance. I also authorize Massabesic Health Resources, P.A. to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE DATE

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PAST MEDICAL HISTORY FORM

Patient Name ______________________________

Height: ______________________________ Weight: ______________________________

BLOOD PRESSURE	YES	NO
Hypertension	☐	☐
Low Blood Pressure	☐	☐
Normal Blood Pressure	☐	☐

HEART DISEASE	YES	NO
Heart Attack	☐	☐
Atherosclerotic Disease	☐	☐
Myocardial Infarction	☐	☐
Rheumatic Heart Disease	☐	☐
Heart Murmur	☐	☐
Do you have a pacemaker	☐	☐

MUSCLE CONDITION	YES	NO
Carpal Tunnel R/L	☐	☐
Tennis Elbow R/L	☐	☐
Back/Neck Problems	☐	☐
Limited Limb Movement	☐	☐

LUNGS	YES	NO
Asthma	☐	☐
Emphysema	☐	☐
Shortness of Breath	☐	☐

JOINT CONDITIONS	YES	NO
Upper Extremity Dislocation	☐	☐
Lower Extremity Dislocation	☐	☐

OTHER CONDITIONS	YES	NO
Muscular Dystrophy	☐	☐
Rheumatoid Arthritis	☐	☐
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Gout	☐	☐
Fibromyalgia	☐	☐
Diabetes	☐	☐
Hearing Loss	☐	☐
Poor Eyesight	☐	☐
Fainting	☐	☐
Polio	☐	☐
Depression/Anxiety	☐	☐

Other: ______________________________

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
☐ None	☐ Sitting	☐ Low	☐ Smoking	Packs a Day ____
☐ 1-2 x Week	☐ Standing	☐ Medium	☐ Alcohol	Drinks a Week ____
☐ 3-4 x Week	☐ Light Labor	☐ High	☐ Coffee/Soda	Cups a Week ____
☐ 5+ x Week	☐ Heavy Labor			

What types of exercise do you perform? : ______________________________

What things cause stress in your life? :

Are you taking any seizure medication? ☐ YES ☐ NO If yes list name: ______________________________

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?

☐ YES ☐ NO If yes list name: ______________________________

List all medications you are currently taking: ______________________________

List all surgeries in the past two years (including dates): ______________________________

Are you pregnant? ☐ YES ☐ NO What week? ____________

Have you had any injuries related to work? ☐ YES ☐ NO If yes list body part and date.: ______________________________

Have you had any Auto Accidents ☐ YES ☐ NO If yes list body part and date.: ______________________________

Have you had Physical Therapy or Massage Therapy before? ☐ YES ☐ NO Where:

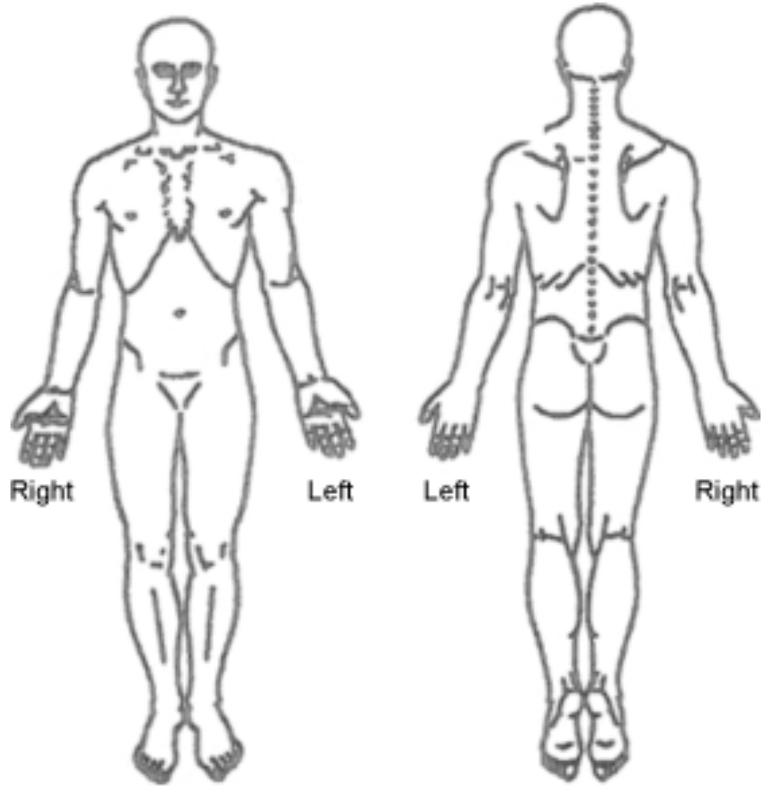
______________________________ ______________________________
Signature of Patient, Parent, Guardian, Personal Representative   Date

Pain and Symptom Status Report

Name ____ Date _____________________________________

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing.

Ache	Burning	Numbness
MMMM MM	– – – – –	OOOO OOO
Pins & Needles	**Stabbing**	**Other**
□□□□□□□□□ □□□□□□	/ / / / / / / / / / / / /	x x x x x x x



Chief Complaint and Visual Analog Scale

My Chief Complaint is: ____

Date First Symptom of Your Problem Occurred on: ________________________

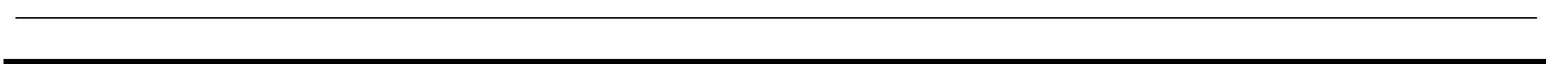
2nd Complaint: ____

3rd Complaint: ____

Please circle on the scale below to indicate your <u>CURRENT</u> level of pain:												
No Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Pain as bad as it gets**
Please circle on the scale below to indicate your AVERAGE level of pain:												
No Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Pain as bad as it gets**
Please circle on the scale below to indicate your WORST level of pain:												
No Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Pain as bad as it gets**

Additional Comments: ____

____



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CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Your protected health information will be used by this practice, known as Massabesic Health Resources, P.A. (MHR) or disclosed to others for the purpose of treatment, obtaining payment or supporting the day-to-day health care operations of the practice.

We are providing you with a copy of our Notice of Privacy Practices. We request that you review the notice prior to signing this consent. You may request a restriction on the use or disclosure of your protected health information. If you wish to restrict your disclosure, you should make that request in writing.

This practice, however, may or may not agree to restrict the disclosure of your protected health information.

If we agree to your request, the restrictions will be binding. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of federal privacy standards.

You may revoke the consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date of your revocation of consent is received will not be affected.

This practice reserves the right to modify the privacy practices outlined in the notice.

SIGNATURE

I have reviewed this consent form and have reviewed the Notice of Privacy Practices. I give my permission to this practice to use and disclose my health information in accordance with it.

____

Name of Patient (Print Clearly)

____

Signature of Patient Date

____

Signature of Patient Representative

____

Relationship of Patient Representative to Patient

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CHECKLIST OF ITEMS TO BRING TO YOUR FIRST VISIT WITH MHR

Attention ALL Patients:

Please bring the following to your first appointment with us:

- Insurance card
- Medication list
- Copy of your referral (if it has not yet been sent to MHR).

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Cancellation/No Show Policy

Attending your treatment sessions on a regular basis is essential to ensure that you receive the most benefit from your physical therapy. The front office staff will work with you to help find the best appointment slots to fit your schedule.

Massabesic Health Resources P.A. requires a 24 hour notice for the cancellation of any scheduled appointment.

We understand that emergencies, poor winter road conditions and other scheduling conflicts may occur. Please call us as soon as you can. For these reasons, we allow for two consecutive cancellations without 24 hour notice. After two such occurrences however, a $40.00 fee will be charged per occurrence. If you are able to reschedule the missed appointment within the same week, no penalty will be assessed.

- After two consecutive no shows or cancellations without proper notice, you will be charged$40.00 per occurrence thereafter.
- This charge ***will not be covered*** by your insurance.

In the event that you need to cancel an appointment, for any reason, please call the office to let us know so that we can adjust our schedules accordingly.

Please take this policy seriously as it could impact payment from your insurer. Accident and Workers Compensation claims adjusters expect regular attendance and adherence to your plan of care.

Your pain may fluctuate as your course of treatment progresses. Having pain or *not* having pain are not reasons to cancel or fail to show for your scheduled treatment. If you are in pain, there are treatments available that can help lessen your pain. Likewise, if you are experiencing less pain, it is important to continue your treatments to correct the underlying causes of the pain. Missing appointments hinders that process and may end up prolonging recovery.

If you have are ever unsure about attending an appointment due to pain, please call to speak with your physical therapist directly.

Thank you for providing us with this courtesy.

Signing below indicates you understand and agree to the terms of this policy.

______________________________ ______________

Signature of PatienUResponsible Party if a minor Date