Massabesic
Health
Resources, P.A.
Orthopedic Manual Physical Therapy, Aquatics, Sports, & Wellness

392 Main St., P.O. Box 456
Waterboro, ME 04087
Tel: (207) 247-3216
Fax (207) 247-3217
Email: mhrpt@mhrpt.com
www.mhrpt.com

Jim Stevenson, PT, FAAOMPT
Hayes Sweeney, MPT
Deidra Ouellette, DPT
Cory Marcoux, DPT

Patient Name: _____

Appointment Day/Time: _____

RE: Upcoming Scheduled Physical Therapy Appointment

Dear Patient,

Enclosed you will find the paperwork that needs to be completed before your scheduled appointment. When you come in for your initial appointment, *please bring in your insurance card(s), your written order from your doctor, a list of your current medications if you take any, and this packet of paperwork all filled out up to 15 minutes prior to your scheduled appointment.*

We *urge* you to call your health insurance company prior to this appointment to verify your outpatient physical therapy benefits. If your coverage will be covered through *Workers Compensation* or *Motor Vehicle* please call us with the following information: *Insurance company name, claim number, claim adjustor's name, adjustor's phone number and FAX number, and date of injury or accident.*

If you have any questions about the above information, please call our office and we will be glad to answer any questions that you may have.

We require a 24-hour cancellation notice for this one-hour appointment if you need to cancel.

Sincerely,

Massabesic Health Resources, PA

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GREATER SPRINGVALE PHYSICAL THERAPY
Orthopedic Manual Physical Therapy, Sports, & Wellness
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Patient Information

First Name: _____ Last Name: _____ Middle Init:____ Date:_____

Mailing Address:_____ City:_____ State:____ Zip:_____

Birth Date:_____ Age:_____ Male: ___ Female: ___ S.S. # _____

Home Phone: _____ Cell Phone: _____

In Case of Emergency

Name of Friend or Relative: _____

Relationship to Patient: _____ Contact Phone: _____

Work Information

Employer: _____ Work Phone: _____

Occupation: _____

Healthcare Provider Information

Referring Doctor: _____ Doctor's Phone: _____

Primary Care Physician (Regular Doctor): _____ Doc's Phone: _____

Insurance Information

Please give your insurance card to the receptionist

Primary Insurance: _____ ID #: _____

Subscriber's Name (if different): _____ Birth Date: _____

Relationship to Subscriber: _____

Secondary Insurance: _____ ID #: _____

Auto or Work Injury Claim

Was this an auto injury claim? YES ___ NO ___ Was this a work injury claim? YES ___ NO ___

Date of Injury: _____ Insurance Name: _____

Address: _____ City:_____ State:____ Zip:_____

Claim #: _____ Cause of Accident: _____

Adjuster Name: _____ Phone: _____ Ext. _____

I authorize my insurance benefits to be paid directly to Massabesic Health Resources, PA. I understand that I am financially responsible for any balance. I also authorize Massabesic Health Resources, PA to release any information required to process my claims.

Patient/Guardian Signature: _____ Date: _____

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Office and Cancellation/No Show Policy

We are dedicated to providing you with the best possible health care and are ready to help receive your maximum allowable benefits if you have medical insurance. To achieve these goals, you can assist us by reviewing our office and cancellation policies below.

Office Policy:

- Your copay is due at the time of service. If you have a deductible that is greater than $500.00, we require a payment of $50.00 per visit to be applied toward that deductible until it has been met. We accept cash, checks, Visa and Mastercard.

- There is a $25.00 service charge on all returned checks. Balances older than 30 days are subject to additional interest charges of 1.5% per month. You are also responsible for any collection fees for overdue accounts sent to a collection agency.

Cancellation/No Show Policy:

Massabesic Health Resources, PA requires a 24-hour notice for the cancellation of any appointment. We understand that emergencies, poor road conditions and other scheduling conflicts may occur, please call us as soon as possible.

- After two consecutive cancellations or no shows without proper notice, you may be charged $40.00 per occurrence thereafter. This charge would **not** be covered by your insurance.
- Accident and Worker's 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 cause of the pain. Missing appointments hinders that process and may end up prolonging recovery.
- If you 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 that you understand and agree to the terms of this policy.

_____ _____

Signature of Patient/or Guardian Date

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Informed Consent and Service Contract

As your sole provider of Physical Therapy, it is our goal to develop a professional and personable relationship with you. With your permission, we will seek to contact members of your healthcare team to better understand your condition. We will explain to you all the treatment details during your Physical Therapy Program before choosing a specific course of treatment. We invite you to be a part of the decision-making process along the way as we work in concert with you and your healthcare team. In the event that we need to contact you:

- **May we leave a message on your home or cell phone? YES NO**
- **List names of any designated people we can leave a message with.**

_____

_____

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment for third party payers.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information and will be provided with that for review upon request. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that you may revoke this consent in writing at any time, except to the extent that you have acted relying on this consent.

Patient Name: _____ **Date:** _____

Signature: _____ **Relationship to Patient:** _____

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PAYMENT AGREEMENT

Assignment of Insurance Benefits

I authorize that the payment of my insurance benefits be made directly to Massabesic Health Resources, PA for any services that are reimbursable by Medicare, Medicaid or any third-party payors.

Guarantee of Payment

I understand that all payments designated as "the patient's responsibility" are due and payable at the time of service or billing. **I guarantee that I will pay:**

My designated portion including co-pays/co-insurance and my deductible.

All amounts due for services that my insurance company has stated are not covered benefits.

All amounts due for services billed by Massabesic Health Resources, PA but paid directly to me.

All amounts due for services billed by Massabesic Health Resources, PA to a Workers' Compensation payor which was subsequently declared by my employer to be a non-eligible claim.

All amounts due for claims submitted by Massabesic Health Resources, PA to my insurance company and not paid by 90 days. We will be in full communication with you and your insurance company in the event of this and will be happy to work with you.

Medicare and Workers Compensation Information

I certify that the information I have provided to Massabesic Health Resources, PA for payment under the Social Security Act (Medicare) or under the Workers Compensation Program is correct, including but not limited to any related accidents/illness or other insurers/payors available.

I, _____, understand the statements I have authorized above
Printed Name
and declare their truthfulness.

_____ _____
Patient or Authorized Representative for Patient Signature Date

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Name:_____ **DOB:** _____ **Height:**_____ **Weight:**_____

CURRENT CONDITION: (this section is continued on back)

What are we seeing you for? _____

Referring Physician: _____ **Primary Care Provider:** _____

Other medical providers you have seen for this injury/condition?:_____

Have you had any imaging? Yes / No ☐ **X-ray** ☐ **MRI** ☐ **CT scan** ☐ **Ultrasound** **If yes, Date:** _____
Results: _____

PAST MEDICAL HISTORY:

	Yes	No		Yes	No	If yes, list joints:
High blood pressure	☐	☐	Osteoarthritis	☐	☐	_____
Low blood pressure	☐	☐	Rheumatoid Arthritis	☐	☐	
Normal blood pressure	☐	☐	Fibromyalgia	☐	☐	
Diabetes	☐	☐	Lyme disease	☐	☐	
Heart attack	☐	☐	Depression	☐	☐	
Heart Disease	☐	☐	Anxiety	☐	☐	
Do you have a pacemaker?	☐	☐	Joint dislocations	☐	☐	_____
Asthma	☐	☐	Joint replacements	☐	☐	_____
Shortness of breath	☐	☐	Poor eyesight	☐	☐	
Emphysema	☐	☐	Hearing loss:	☐	☐	
COPD	☐	☐	Cancer	☐	☐	Type:_____
Epilepsy	☐	☐	Pregnant	☐	☐	Week:_____
Fainting	☐	☐				

Surgical history :_____ Other:_____

Please check all that apply:

EXERCISE:
- ☐ None
- ☐ 1-2 x /week
- ☐ 3-4 x/week
- ☐ 5+ x/week

Type of exercise:
_____
_____
_____

WORK ACTIVITY:
- ☐ Sitting
- ☐ Standing
- ☐ Light labor
- ☐ Heavy labor

Occupation:
_____
_____

STRESS LEVEL:
- ☐ Low
- ☐ Medium
- ☐ High

What causes stress?
_____
_____

HABITS:
- ☐ Smoking packs/day: ___
- ☐ Alcohol drinks/wk:___
- ☐ Coffee cups/wk: ____
- ☐ Soda drinks/wk: ___
- ☐ Healthy diet
- ☐ Unhealthy diet

CURRENT MEDICATIONS: Please list all and what they are for.

_____
_____
_____
_____

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Pain and Symptom Status:

Briefly describe your symptoms: _____

_____

_____

_____

Please circle on the scale below to indicate your CURRENT 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: _____

_____

_____

_____

_____