

Patient Information

Clients Name		Middle Initial		Sex	M	F
Date of Birth		Social Security #		-	-	
Address		City		State		Zip
Phone		Client Status: Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>				
Cell Phone		E-Mail :				

Employment Information Employed Full Time Student Part Time Student

Employer/ Student :					
Address :					
Phone :					
Emergency Contact Person		Phone:		Relation:	

Is Your Injury Related To:

A. Employment? (Current Or Previous)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	B. Auto Accident?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	C. Other Accident?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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Name Of Primary Care Physician		MD UPIN#	
Name Of Referring Physician		MD UPIN#	

Insurance Information: Patient's Relationship To Insured: Self Spouse Child Other

Name :		Insured DOB:	
Address:			

Note : We will need to copy your insurance card.

	Primary Insurance Information	Secondary Insurance Information
Carrier:		
Address/ P.O. Box :		
Phone:		
Group:		
Claim #/ ID :		
Adjuster:		

For Office Use Only!!!!

Diagnosis:		ICD9:	
Diagnosis:		ICD9:	
Diagnosis:		ICD9:	
Deductible: \$	Co-pay/Ins: \$	Ins Covers:	Limitations:

Dynamic Physical Therapy Services 111 Elm Street Suite 103
Worcester, Ma 01609
Phone:(508)799-6538 O Fax: (508)799-5535

Patient Name _____ Date _____

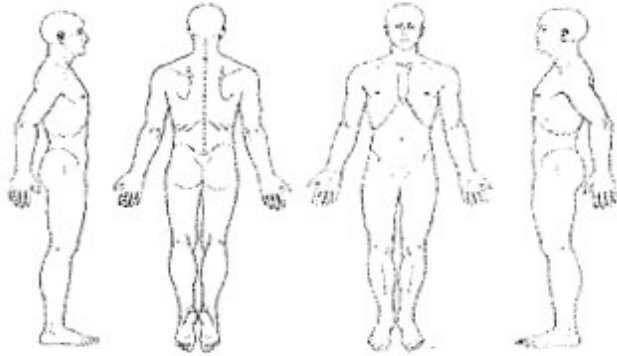
1. Describe your symptoms

a. When did your symptoms start?

b. How did your symptoms begin?

2. How often do you experience your symptoms? Indicate where you have pain or other symptoms

- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)



3. What describes the nature of your symptoms?

- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- ⑥ Tingling

4. How are your symptoms changing?

- ① Getting Better
- ② Not Changing
- ③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

- ① Not at all
- ② A little bit
- ③ Moderately
- ④ Quite a bit
- ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?

(like visiting with friends, relatives, etc)

- ① All of the time
- ② Most of the time
- ③ Some of the time
- ④ A little of the time
- ⑤ None of the time

7. In general would you say your overall health right now is...

- ① Excellent
- ② Very Good
- ③ Good
- ④ Fair
- ⑤ Poor

8. Who have you seen for your symptoms?

- ① No One
- ② Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

a. What treatment did you receive and when?

b. What tests have you had for your symptoms and when were they performed?

- ① Xrays date: _____
- ② MRI date: _____
- ③ CT Scan date: _____
- ④ Other date: _____

9. Have you had similar symptoms in the past?

- ① Yes
- ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

- ① This Office
- ② Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

10. What is your occupation?

- ① Professional/Executive
- ② White Collar/Secretarial
- ③ Tradesperson
- ④ Laborer
- ⑤ Homemaker
- ⑥ FT Student
- ⑦ Retired
- ⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

- ① Full-time
- ② Part-time
- ③ Self-employed
- ④ Unemployed
- ⑤ Off work
- ⑥ Other

Patient Signature _____ Date _____

Our Financial Policy

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. **You clear understanding of this Financial Policy is important to our professional relationship.** Please ask us any questions about our fees, policy, or your responsibility.

Primary Insurance - We file claims as a courtesy to you. However, if we do not receive payment within 90 days, you will be held responsible. The full balance is due upon receipt of invoice. **We still not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered chargers, Secondary Insurance, "usual and customary" charges etc., other than to supply factual information as necessary to pay a claim. Co-pays and deductible are due at time of visit. You may also be billed for non-covered charges.**

Automobile Medical Insurance- We will bill the automobile insurance company for your treatment provided that there is available coverage with the policy. If you do not have coverage, payment is due at time of your treatment. We will provide you with documentation at your request in order to facilitate reimbursement upon settlement of your case

Workers Compensation- We will bill your workers compensation carrier for your charges. In the event of claim denial or fraud, you will become financially responsible for all treatment charges.

Cash- Please pay balance in full at time of service or upon receipt of invoice. Failure to maintain these agreements may result in the placement of your account with an agency for collection.

Cancellation Policy- We require **24 - HOURS notice for cancellation of a scheduled appointment. Failure to comply with policy will result in a \$ 25. 00 charge.** The charge will be billed to you directly.

I authorize the release of any medical or other information necessary to process this claim. I authorize payment of medical and, if applicable, government benefits to Dynamic Physical Therapy Services. I assign all payments for physical therapy services to Dynamic Physical therapy Services.

I agree that I am responsible for payment of my physical therapy invoices, whether or not my insurance company is paying them. I agree to pay the charges for appointments not cancelled twenty-four hours in advance. Payment is due upon receipt of invoice. Please sign and date this form to indicate that you understand and agree to the terms of this payment policy. **Please let us know if you have any questions or concerns.**

Signature Of Responsible Party _____ Date _____

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