FLAHERTY
PHYSICAL THERAPY

411 West Main Street, Suite 3
Northborough, MA 01532
p: 508-393-9000 **f:** 508-393-9525
e: info@flahertyphysicaltherapy.com
w: www.flahertyphysicaltherapy.com

Welcome to Flaherty Physical Therapy!

PATIENT'S RIGHTS AND RESPONSIBILITIES

Every patient shall have the right:

1. To receive medical care that meets the highest standards of Flaherty PT and upon request, to obtain from the facility the name and credentials of the physical therapist, physical therapy assistant or other person responsible for his care or the coordination of his care.
2. To be treated respectfully by all the staff members of Flaherty PT.
3. To have confidentiality of all records and communications to the extent provided by law and upon request, to inspect his/her medical records and to receive a copy thereof and the fee for said copy shall be determined by the rate of copying expenses.
4. To take part in the development and implementation of his/her plan of care, to make informed decisions regarding his/her care, to receive information of his/her care, and to request and refuse treatment.
5. To have privacy during medical treatment or other rendering of care within the capacity of Flaherty PT.
6. To have all reasonable requests responded to promptly and adequately within the capacity of Flaherty PT including obtaining information necessary for the patient to understand his/her medical situation and to receive information about how the patient can get assistance with concerns and complaints about the quality of care or service he/she received, and to initiate a formal grievance process with the facility.
7. Upon request, to receive from a person designated by the facility any information which the facility has available relative to financial responsibilities of the patient and upon request, to receive a copy of an itemized bill or other statement of charges submitted to any third party by the facility for care of patient.
8. To refuse to be examined, observed, or treated by students or any other staff member without jeopardizing access to medical care.
9. To prompt life-saving treatment in an emergency without discrimination on account of economic status or source of payment.

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PATIENT'S RIGHTS AND RESPONSIBILITIES (CONT.)

Every patient of Flaherty PT shall have the responsibility to:

1. Enjoy their time in the clinic and have fun while exercising!
2. Sign the required consents prior to care being given or received.
3. Provide Flaherty PT complete and accurate health information and notify the facility of any changes in his/her medical condition, new diagnoses, medical procedures, surgeries, or doctor's visits or admission to a home health agency service while receiving physical therapy care with this facility.
4. Provide Flaherty PT with complete and accurate health and insurance information and all necessary signatures required for processing of payment for services furnished and to notify the facility of any changes of health insurer. Also alert your therapist of any health related changes either specific to or not specific to the treatment area being treated.
5. Treat the staff and other clients of Flaherty PT with respect and consideration and notify the facility when you cannot keep an appointment.
6. Provide Flaherty PT payment after services have been rendered.
7. Follow the treatment plan (home activities, recommended lifestyle changes and performance of a home exercise program) recommended by the physical therapist and let the physical therapist know immediately if the patient does not understand his/her plan of care. Accept the consequences of refusal of treatment or choice of non-compliance with therapeutic program and advice regarding the planning and participation of his/her care.

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Patient Registration Form

Name: _____ Date of Birth: ____/_____/___
First Middle Last

Address: _____
Street Address Town State Zip Code

Home Phone: (_____) _____ Cell Phone: (_____) _____

Email: _____

Emergency Contact: _____
First Name Last Name Contact phone number

Primary Care Physician: _____ Referring Physician: _____

Primary Health Insurance Information: _____

Name of Subscriber (if not patient): _____

Subscriber's date of birth: ____/___/____ Subscriber's employer: _____

Secondary Health Insurance Information: _____

Are your injuries a result of a motor vehicle accident? ❑ Yes ❑ No Date _____

Are your injuries a result of a worker's compensation accident? ❑ Yes ❑ No Date _____

If the answer to the above question is yes, please provide our office staff with all appropriate information so that we can appropriately bill for your physical therapy services.

ASSIGNMENT AND RELEASE – I hereby authorize and direct my insurance benefits to be paid directly to Flaherty Physical Therapy, Inc. I understand that I am financially responsible for non-covered services. I also authorize Flaherty PT to release any information according to Flaherty PT policy and HIPPA regulations (for patients who are under the age of 18, a signature from the parent/guardian is required).

Print Name: _____ Relation to Patient: _____

Signature: _____ Date: _____

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Informed Consent for Physical Therapy Care

I, hereby agree to a physical therapy evaluation and routine treatment by a Massachusetts licensed physical therapist or under his/her supervision, a Massachusetts licensed physical therapy assistant. I understand that the physical therapy treatment will be provided for the identification, prevention, remediation, and rehabilitation of an acute or chronic physical dysfunction. I understand that my physical therapist/physical therapist assistant will have me involved in the decisions of my care at all times. My consent to any treatment set forth is voluntary and I may withdraw any such consent at any time and to any aspect of the prescribed treatment.

Benefits to be expected

Although no assurance can be given and every case is individual, common benefits associated with regular participation in a physical therapy program include, but are not limited to, improvement in joint range of motion/flexibility, muscle strength, cardiovascular endurance, physical performance, body mechanics, decreased pain levels, and reduction in future injury risk with the primary goal to restore maximum functional independence.

Risks and Discomforts

As with any medical procedure or treatment there are risks. These include abnormal blood pressure, fainting, disorders of heart rhythm, excessive perspiration and, in very rare instances, heart attack, stroke or death. Every effort will be made to minimize those risks by the initial examination/evaluation and by observations during the therapy sessions. If you have any concerns or questions about a particular portion of the proposed treatment, please notify your physical therapist or physical therapy assistant and he/she will address these issues.

Your responsibility as a patient

To gain the expected benefits, you must give priority to regular attendance and adherence to prescribed amounts of intensity, duration frequency, progression and type of activity and will report any unusual symptom which you experience before during or after a physical therapy treatment session.

I have read, or have had read to me the above consent. By signing below, I agree, or agree to have my child, receive routine physical therapy treatment as explained to me by the treating physical therapist. My signature also attests to the fact that I have been given Patient's Rights and Responsibilities and Notice of Privacy Practices and been given ample opportunity to review it. I intend this consent to cover the entire course of treatments for my condition for which I seek treatments from Flaherty Physical Therapy, Inc.

Date Patient name (please print) Patient Signature

Parent or Guardian name and Signature (if patient is less than 18 years of age)

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Payment Information

We are pleased that you decided to trust us with your physical therapy care. We are hopeful that your experience with us will be outstanding from start to finish. The following is some information in regard to the finances of your visit.

Payment Policy

Payment for physical therapy treatment is ultimately the responsibility of the patient. For those who have health insurance, we will file claims on your behalf. Should your health insurance coverage expire or terminate while you are still being treated, let us know and further options will be discussed. For Workers Compensation cases, we will bill third-party payers. The patient will be responsible for any collection costs, should the use of a collections agency be required to receive payment on your account.

Co-payments, Co-insurance, and Deductibles

Our front office will verify your physical therapy insurance benefit prior to your first visit. This will be reviewed with you on your first visit. We require that payments be paid at the time that our services are rendered, unless other arrangements have been made. Co-insurances (typically a percentage of the allowed insurance payment) will be estimated, and once the explanations of benefits (EOB's) are received, we will review the balance and adjust accordingly. Cash, check and MasterCard/Visa are acceptable forms of payment. There is a $20.00 minimum fee on returned checks.

Cancellations

We are aware that at times you may be unable to attend your scheduled visits. As a courtesy, please give us at least 48 hours' notice if you will be canceling. This will allow us to provide care to another patient that may be waiting for treatment. Attendance of your scheduled visits is critical to allow us to consistently treat you and maximize your gains from physical therapy. Your physical therapist will review with you our Attendance Policy on your first visit.

Thank you for giving us the opportunity to serve you. Please feel free to ask us any questions about our services, policies and fees.

Date Patient name (please print) Patient Signature

Parent or Guardian name and Signature (if patient is less than 18 years of age)

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Flaherty Physical Therapy Attendance Policy

Because we want you to have the most successful rehab experience possible, we would like to stress the IMPORTANCE of your attendance to all of your scheduled appointments.

Your success depends on your commitment. Please make physical therapy your priority over the next few weeks. Remember, you are only being asked to come for about 1-3 hours each week. Due to that, you need to be as consistent as you can so you can get the best outcome from your rehab. Your therapist will give you a recommended treatment plan. You need to keep all of your appointments with the exception of a serious emergency. In instances of repeated “no shows” or last minute cancellations we reserve the right to discontinue your treatment. We will inform your physician that you were not compliant with the prescribed PT order and suggest that you wait until you can commit more time to your therapy.

******If you absolutely cannot make your scheduled appointment…****

We kindly ask for a phone call with at least 48 HOURS notice. We will work with you to reschedule your appointment for another time later that week so that way you will not miss your PT session.

If your appointment is LESS than 48 HOURS, we will make every attempt to fill your spot with another patient. However, we reserve the right to charge you $20 if we are not able to fill it.

If NO CALL is made to cancel your appointment, we will charge you our “No show” fee of $20 which must be paid at the time of your next visit. This fee cannot be billed to your insurance company.

We appreciate you greatly as our patient and strive to accomplish wonderful results and success with you.

I understand and agree to adhere to the Flaherty Physical Therapy attendance policy.

Patient Signature: _____ Date: _____

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Medical History for Physical Therapy Care

Name: _____ Age: _____ Sex: ❑ M ❑ F

What is the date of your next physician visit? _____

Have you received any X-rays or MRI related to your injury? ❑ Yes ❑ No

Have you had any surgeries in the past? ❑ Yes ❑ No

If yes, please specify: _____

Have you had physical therapy in the past year? ❑ Yes ❑ No

If yes, please note where and when: _____

Do you have any current allergies we should be aware of? ❑ Yes ❑ No

If yes, please specify: _____

Please answer yes or no to the following:

Medical History	Yes	No	Medical History	Yes	No
Anxiety/Depression			Heart Attack/Surgery		
Asthma/Hay Fever			Immune Deficiency/Disease		
Arthritis			Joint Replacement Surgery		
Back injury or pain			Kidney Disease		
Neck Injury of pain			Liver Disease/Hepatitis		
Cancer/Tumor			Lung Disease/Tuberculosis		
Chest Pain			Osteoporosis		
Clotting/Bleeding Disorder			Neurological Disease/Stroke		
Convulsions/Epilepsy			Pace Maker/Defibrillator		
Diabetes			Skin Disorders/Psoriasis		
Eye Issues/Glaucoma/Cataract			Thyroid Disease		
Fractures			Vertigo/Vestibular Issues		
High Blood Pressure			OTHER:		
Do you smoke?					

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What makes the pain/symptoms increase? ❑ Work ❑ Sports ❑ Standing ❑ Sitting

❑ Other: _____

What makes the pain/symptoms decrease? ❑ Rest ❑ Heat ❑ Medications ❑ Standing ❑ Sitting
❑ Lying Down ❑ Sleeping ❑ Ice ❑ Exercise

❑ Other: _____

How often do you have your symptoms? ❑ Constantly ❑ Occasionally ❑ Rarely

❑ Only when I _____

Are your symptoms? ❑ Improving ❑ Worsening ❑ Staying the same

Current Limitations with Functional activities:
Because of my current complaint I am having difficulty (fill in on the line below)

_____

What would your rate your pain/symptoms:

At worst:

0 1 2 3 4 5 6 7 8 9 10
No pain Minor Moderate Severe Worst pain ever

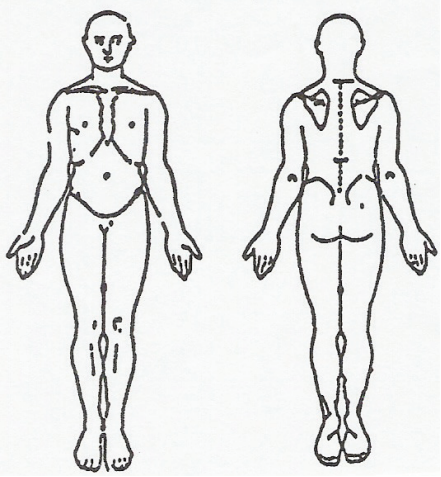
At best:

0 1 2 3 4 5 6 7 8 9 10
No pain Minor Moderate Severe Worst pain ever

Currently:

0 1 2 3 4 5 6 7 8 9 10
No pain Minor Moderate Severe Worst pain ever

Pain Diagram
Please shade areas of pain below



What are your current goals for physical therapy?

_____

What is your current exercise regime like now?

_____

Who can we thank for referring you to Flaherty Physical Therapy? _____

Have you seen any promotional information about Flaherty PT? ❑ Yes ❑ No

Where did you see it? _____

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Current Medication Form

Patient Name: _____Date:_____

Please list all prescription medication, over the counter medication, herbals, or vitamin/dietary supplements you are presently taking.

Medication Name	Dosage	Frequency [Circle which applies]	Route [Circle which applies]
		Once a day / Twice a day / Other:	Oral / Injection
		Once a day / Twice a day / Other:	Oral / Injection
		Once a day / Twice a day / Other:	Oral / Injection
		Once a day / Twice a day / Other:	Oral / Injection
		Once a day / Twice a day / Other:	Oral / Injection
		Once a day / Twice a day / Other:	Oral / Injection
		Once a day / Twice a day / Other:	Oral / Injection
		Once a day / Twice a day / Other:	Oral / Injection

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