

DRAC Physical Therapy
Patient Registration Form
Please Print Clearly

PATIENT INFORMATION

TODAY'S DATE: __/__/__

LAST NAME: _____ FIRST NAME: _____ MI: _____

SEX: ☐ M ☐ F HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____

DATE OF BIRTH: __/__/__ SOCIAL SECURITY #: _____ - _____ - _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ OTHER EMPLOYED: ☐ YES ☐ NO

EMPLOYER/SCHOOL: _____ WORK PHONE: _____

EMAIL ADDRESS: _____

IN CASE OF EMERGENCY CALL:

NAME: _____ PH NUMBER# _____

INSURANCE INFORMATION

****PLEASE LET THE RECEPTIONIST KNOW IF YOUR INJURY IS WORK OR MOTOR VEHICLE RELATED. FAILURE TO PROVIDE ALL NEEDED INSURANCE INFORMATION RESULTS IN CHARGES DIRECTLY TO THE PATIENT OR GUARANTOR****

PRIMARY INSURANCE: _____ ID# _____

GROUP# (if applicable): _____ POLICY HOLDER: _____

DOB: __/__/__ SSN: ____ - ____ - ____ RELATIONSHIP TO POLICY HOLDER: _____

SECONDARY INSURANCE: _____ ID# _____

GROUP# (if applicable): _____ POLICY HOLDER: _____

DOB: __/__/__ SSN: ____ - ____ - ____ RELATIONSHIP TO POLICY HOLDER: _____

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NO SHOW/LATE CANCELLATION POLICY

AS A CONVENIENCE TO OUR PATIENTS, WE ARE ABLE TO SEND OUT AUTOMATIC REMINDERS 24 HOURS BEFORE EACH APPOINTMENT. THESE REMINDERS WILL ENSURE YOU ARRIVE ON THE RIGHT DAY AT THE RIGHT TIME, THUS AVOIDING A LATE CANCELLATION OR NO SHOW FEE. PLEASE SELECT A REMINDER METHOD BELOW AND UNDERSTAND ANY APPOINTMENT NOT CANCELLED WITHIN **24 HOURS** OR SCHEDULED AND NOT ATTENDED IS SUBJECT TO OUR \$35 FEE. **THIS FEE MUST BE PAID BEFORE YOUR NEXT SESSION.** ANY PATIENT WITH 3 OR MORE NO SHOW/LATE CANCELLATION'S WILL BE DISCHARGED FROM OUR CARE DUE TO NON COMPLIANCE. THANK YOU FOR YOUR COOPERATION.

I WOULD LIKE TO BE REMINDED VIA:

☐ PHONE CALL: (_____)_____-_____

☐ TEXT MESSAGE: (_____)_____-_____

☐ EMAIL: _____@_____.COM

Please note all reminders are done through our computer system and you are unable to cancel via the automated emails, calls or text messages. Cancellations must be made via phone to our office, if you are calling outside of office hours please make sure you leave a clear and detailed message.

NO SHOW/CANCELLATION POLICY AGREEMENT

I UNDERSTAND ANY APPOINTMENT I SCHEDULE AND DO NOT ATTEND **OR** SCHEDULE AND DO NOT CANCEL WITHIN 24 HOURS WARRANTS A \$35 NO SHOW FEE WHICH MUST BE PAID BEFORE MY NEXT APPOINTMENT.

SIGNATURE:_____DATE:_____

COMPLETE ALL SECTIONS

REFERRING DR: _____

LOCATION & PHONE NUMBER: _____

PRIMARY CARE DR: _____

LOCATION & PHONE NUMBER: _____

HOW DID YOU HEAR ABOUT US?

PRIMARY CARE DR ☐

WORD OF MOUTH ☐

SPECIALIST ☐

DHAC BROCHURE ☐

OTHER: _____

HAVE YOU HAD PHYSICAL THERAPY THIS CALENDAR YEAR?

YES: ☐

NO: ☐

IS THIS INJURY WORK RELATED? (SEE RECEPTIONIST FOR ADDITIONAL PAPERWORK IF YES)

YES: ☐

NO: ☐

IF YES DO YOU HAVE A CLAIM ON FILE?

YES: ☐

NO: ☐

IS THIS INJURY THE RESULT OF A MOTOR VEHICLE ACCIDENT? (SEE RECEPTIONIST FOR ADDITIONAL PAPERWORK IF YES)

YES: ☐

NO: ☐

IF YES DO YOU HAVE AN OPEN CLAIM WITH YOUR PERSONAL MOTOR VEHICLE INSURANCE CARRIER?

YES: ☐

NO: ☐

HAVE YOU HAD HOME PHYSICAL THERAPY OR VNA SERVICES?

YES: ☐

NO: ☐

IS THIS INJURY THE RESULT OF A FALL?

YES: ☐

NO: ☐

IF YES WHERE DID YOU FALL : _____

HOW MANY FALLS HAVE YOU HAD THIS YEAR? _____

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NAME: _____ **OCCUPATION:** _____ **AGE:** _____

DATE OF INJURY: _____ **DATE OF SURGERY (if applicable):** _____

BRIEFLY DESCRIBE HOW YOU WERE INJURED: _____

DO YOU EXERCISE REGULARLY? YES _____ NO _____

IF YES, BY WHAT MEANS? _____

HAVE YOU HAD AN IMAGING FOR THIS CONDITION? (X-RAY, MRI, CT SCAN) YES _____ NO _____

IF YES, WHAT WERE THE RESULTS? _____

ARE YOU COMFORTABLE WITH AQUATIC EXERCISE? YES _____ NO _____

ARE YOU PRESENTLY TAKING ANY MEDICATIONS? (If yes, please list below) YES _____ NO _____

MEDICATION NAME	DOSAGE	REASON

PLEASE INITIAL AFTER READING THE FOLLOWING TERMS!!

RELEASE OF MEDICAL RECORDS:

I hereby consent to the release of any and all records and information or copies related to my physician, nurse safety officer, rehabilitation specialist, insurance company or attorney when appropriate. I also understand that regular reports will be provided to them as requested and as they relate to my treatment and progress.

Your initials _____

DEDUCTIBLE AND CO-INSURANCE AGREEMENTS:

I hereby agree to pay all the deductible and co-insurance payments if required by the policies of my insurance coverage. I further agree to pay these bills upon notification. Failure to comply with reimbursement of balances owed may lead to collection activity.

Your initials _____

PREVIOUS TREATMENT:

I understand that it is my responsibility to inform staff at DRAC PT if I have received medical treatment elsewhere for the same or any other injuries because I might have used part of, if not all my insurance benefits. It is also my responsibility to find out the availability of my physical therapy benefit from my insurance company if I have been treated for the same or other injuries before. By not providing this important information, I will be held responsible for the claims in full that are rejected by my insurance company due to benefit exhaustion.

Your initials _____

INSURANCE BENEFIT AND REFERRALS:

I understand that it is my responsibility to verify physical therapy benefits with my insurance company. If my insurance policy requires referrals from a dedicated source, (for example, primary care physician), I am responsible to provide one at the time of my initial visit, and to provide more as needed to continue treatment. I will keep track of my visits not to exceed the number of visits authorized on the referral and not go beyond the expiration date. I will be responsible for visits that are not covered by referrals. As courtesy, staff at DRAC PT will inform me when a referral is needed.

Your initials _____

CONSENT TO RENDER PAYMENT:

I hereby authorize the payment of medical benefits to DRAC PT for services rendered to me, or others for whose medical benefit I am responsible. DRAC PT agrees to bill my insurance company as a courtesy; however, should the insurance company pend or deny claims beyond 60 days of submission, I will be responsible for payment in full to DRAC PT within upon notification from insurance company or DRAC PT billing department.

Your initials _____

CO-PAY:

I understand that my co-pay is due at the time of service. DRAC PT reserves the right to reschedule appointments for outstanding balances.

Your initials _____

PRIVACY NOTICE:

I have received DRAC PT's Notice of Privacy Practices.

Your initials _____

TREATING THERAPIST

I UNDERSTAND THAT AFTER MY EVALUATION TODAY, MY APPOINTMENTS MAY BE BOOKED WITH ANOTHER THERAPIST. WE WOULD LIKE TO APOLOGIZE FOR ANY INCONVENIENCE THIS MAY CAUSE TO YOU.

Your initials _____

By signing below, I acknowledge that I have agreed to the above mentioned policies, and consent for DRAC Physical Therapy, Inc to render treatment.

SIGNATURE: _____ DATE: _____



200 Providence Highway
Dedham, Massachusetts 02026

MEDICARE PATIENTS

Dear Valued Medicare Patient,

- Please be advised that Medicare will only cover services deemed “reasonable and necessary” by the Center for Medicare and Medicaid Services(CMS). CMS indicates “to be covered, services must be **skilled** therapy services. Services provided by professionals who do not meet the qualification standards are unskilled services. Unskilled services are palliative procedures that are **repetitive or reinforce previously learned skills, or maintain function after a maintenance program has been developed.**” In other words, your therapist is a trained, licensed professional who is responsible for determining whether therapy becomes maintenance in nature. Once therapy is determined to be maintenance in nature by your therapist, Medicare will no longer accept responsibility for payment, and you will be held responsible for balances of any continued treatment.
- Please be advised that effective **January 1, 2013**, Medicare imposed a financial limitation of **\$1,900.00** per calendar year for outpatient rehabilitation services(physical therapy and speech/language pathology combined). Should you have any questions regarding this matter, please feel free to contact Medicare’s customer service department and/or speak with your physical therapist.
- Please be advised that Medicare requires a new prescription once your existing one expires(Prescriptions with no frequency or duration default to 30 days). It is your responsibility to be sure you have a current prescription on file. If you do not have a current prescription on file, you will be responsible for any visit that does not fall within the Medicare guidelines.
- Please be advised that Medicare will not pay for outpatient physical therapy if you are receiving and home health services. Please understand that you will be responsible for any balance incurred because you have not disclosed to us that you are also receiving services at home.

Are you currently receiving home health services? YES _____ NO _____
(Inquire with a staff member if you are unsure as to what constitutes “home health services”)

Please sign below stating that you have read
And understood Medicare’s policies

Signature: _____ Date: _____

****THIS PAGE IS OPTIONAL****

AUTHORIZATION TO KEEP CREDIT CARD ON FILE

DRAC Physical Therapy
200 Providence Highway
Dedham, MA 02026
781-326-8332

By signing the bottom of this page, I authorize DRAC Physical Therapy to charge my credit card for C0-Payments/Balance due of charges not paid by my insurance (including no show fees). I understand this form is valid for one year from the date signed unless I cancel the authorization through written notice to DRAC Physical Therapy.

Signature: _____ *Date:* _____

Patient Name & Address: _____

Bankcard Payment Authorization:

_____ *American Express*

_____ *Visa*

_____ *MasterCard*

_____ *Discover*

Credit Card Account Number: _____

Expiration Date: _____

Name as shown on Credit Card: _____

Cardholder Signature: _____