Dedham Health Physical Therapy (DRAC Physical Therapy)

Patient Registration Form

Please Print Clearly

TODAY'S DATE: ____/____/____

FIRST NAME: _____ LAST NAME: _____ MI: _____

DATE OF BIRTH: ____/____/____ SEX: ☐ M ☐ F

MAILING ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

PERSONAL EMAIL ADDRESS: _____

*Please note we do **not** sell or solicit your email information

EMERGENCY CONTACT: NAME: _____ RELATION: _____ PHONE: _____

HOW WOULD YOU LIKE TO BE REMINDED OF YOUR APPOINTMENT?

☐ PHONE CALL: (_____) _____ - _____ ☐ TEXT MESSAGE: (_____) _____ - _____

DOCTOR'S INFORMATION

REFERRING DR/SPECIALIST: _____ **PHONE NUMBER:** _____

PRIMARY CARE DR: _____ **PHONE NUMBER:** _____

HAVE YOU HAD PHYSICAL THERAPY WITHIN THE PAST 365 DAYS? ☐ YES ☐ NO

IF YES, HOW MANY VISITS: _____

MEDICAL INFORMATION

OCCUPATION: _____ **AGE:** _____ **HEIGHT:** ____**FT**____**IN** **WEIGHT:** _____

DO YOU NOW, OR HAVE YOU EVER HAD ANY MEDICAL ISSUES/CONDITIONS AND/OR SURGERY? (IF YES, PLEASE LIST BELOW)

_____

_____

ARE YOU PRESENTLY TAKING ANY MEDICATIONS? IF YES, PLEASE LIST THE MEDICATION NAME BELOW. (USE THE BACK SIDE IF NEEDED OR PROVIDE A LIST)

MEDICATION	DOSAGE	REASON

Please rate your pain on a scale from 0-10 (0 being no pain, 10 being emergency room pain):

0----1----2----3----4----5----6----7----8----9----10

At Worst, My Pain Is: ___/10 **My Current Pain Is: ___/10** **At Best, My Pain Is: ___/10**

How would you describe your pain (please circle):

Deep/Achy	Throbbing	Sharp	Electric	Burning	Pins/Needles
Shooting	Worse in AM	Worse in PM	Constant	Intermittent	Dull/Sore

WHERE IS YOUR PAIN LOCATED? _____

DATE OF ONSET/INJURY: _____

HAVE YOU HAD SURGERY? IF SO, WHEN? _____

HOW DID THIS INJURY OCCUR? _____

_____

DID YOU HAVE X-RAY'S OR AN MRI? IF SO, WHAT WERE THE FINDINGS? _____

_____

INSURANCE INFORMATION

* FAILURE TO PROVIDE ALL NEEDED INSURANCE INFORMATION COULD RESULT IN CHARGES DIRECTLY TO THE PATIENT OR GUARANTOR**

PRIMARY INSURANCE: _____ ID#: _____

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

POLICY HOLDER DOB: ____/____/____ RELATIONSHIP TO POLICY HOLDER: _____

SECONDARY INSURANCE: _____ ID#: _____

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

DOB: ____/____/____ RELATIONSHIP TO POLICY HOLDER: _____

IS THIS A WORK RELATED INJURY? ☐ YES ☐ NO (If yes, please complete box below)

IS THIS INJURY A RESULT OF A MOTOR VEHICLE ACCIDENT? ☐ YES ☐ NO (If yes, please complete box below)

IF YOU HAD AN AUTO OR WORK RELATED ACCIDENT PLEASE COMPLETE THIS SECTION:

DATE OF ACCIDENT: _____ CLAIM NUMBER: _____

Insurance Company Name: _____

Address of Insurance Company: _____

Claims Adjuster: _____ Adjuster Phone Number: _____

Worker's Compensation patients: Name of Employer: _____ Phone: _____

Motor Vehicle Patients:

Please provide the insurance company and claim number of the vehicle you were in, NOT the other driver's information

Have you returned your PIP Application to Insurance Company? Yes_____ No_____

Have you exhausted your PIP yet? Yes_____ No_____ Don't Know_____

Dedham Health Physical Therapy (DRAC PT Inc.)
https://dedhamhealthphysicaltherapy.com/
200 Providence Highway
Dedham, MA 02026

P: 781-326-8332
F: 781-326-8262

COPAY, DEDUCTIBLE AND CO-INSURANCE AGREEMENTS:

DRAC Physical Therapy reserves the right to reschedule my appointment due to outstanding balances.

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 all balances owed may lead to collection activity.

PREVIOUS TREATMENT:

I understand it is my responsibility to inform staff at DRAC Physical Therapy if I have received medical treatment elsewhere for the same or any other injuries because I might have used part of, if not all, of 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 any/all claims denied by my insurance due to benefit exhaustion.

RELEASE OF MEDICAL RECORDS:

I hereby consent to the release of any and all records, information, or copies related to my physician, nurse case manager, 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.

PRIVACY NOTICE:

Dedham Health's Privacy Policy is posted in our lobby and also included at the end of this packet. If you would like to receive Dedham Health's Privacy Notice, please ask reception for a copy.

TREATING THERAPIST:

I understand that after my evaluation today my appointments may be scheduled with another therapist. We would like to apologize for any inconvenience this may cause to you.

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

Patient Signature:_____ **Date:**_____

HOW DID YOU HEAR ABOUT US?

☐ AD/NEWSLETTER ☐ FACEBOOK ☐ INSTAGRAM ☐ FRIEND/FAMILY ☐ DOCTOR ☐ OTHER:_____

CANCELLATION & NO SHOW POLICY

We value your time as our patient and strive to provide each patient with the highest quality of care. Keeping all of your regularly scheduled appointments is critical to not only the extent of your recovery, but also to the speed with which you will be able to return to your activities and passions. **This is the most important reason as to why we have a cancellation policy.** We hope that you will also value the time of our therapists by calling our office if you are unable to keep your appointment. Late cancellations and no show appointments affect not only the success in your recovery, but it compromises our ability to accommodate the scheduling needs of our other patients. *Cancellations are requested within **24 hours** of your appointment.*

We offer automated appointment reminders either by text or phone call so please confirm with a staff member the information we have on file is correct to ensure you receive these notifications.

- **First No-Show/Late cancellation**: You will receive a phone call informing you that you missed the scheduled appointment and any additional infractions will result in a charge.
- **Second No-Show/Late cancellation**: You will receive notification that two (2) appointments have now been missed without notifying the office within the appropriate time frame and you will be charged a $35.00 fee*.
- **Third No-Show/Late cancellation**: You will receive notification regarding your no-show history and you will be charged a $35.00 fee*. Additional infractions may result in same day scheduling ONLY and possible dismissal from the clinic.

**THE PATIENT IS RESPONSIBLE FOR THE FEE(S) INCURRED. They are NOT charged to the insurance/third party payer.*

Furthermore, 3 consecutive no-shows or excessive late cancellations will result in the cancellation of all remaining scheduled appointments. A discharge note will be sent to the referring physician and insurance company indicating non-compliance of therapy. If therapy needs to be resumed, we will require a new referral from your physician.

Things to please keep in mind if you need to cancel:

- **Do not** try to respond to the appointment reminders by e-mail or text. They are automatically sent through our EMR software
- **Do** call our clinic to leave a message or speak to a staff member.
- If we can re-schedule you **within 24 hours**, it will not be considered a late cancel.
- If you need to cancel a Monday appointment, you must call by the close of Friday prior

WC PATIENTS: If you are a workers' compensation patient, we are required to inform your case manager/adjuster of any missed appointments. These will be reported as necessary.

_____ _____ / _____ / _____

Patient Acknowledgement/Signature Date

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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 discharged or held responsible for balances of any continued treatment.
- Please be advised that effective January 1, 2020, Medicare imposed a financial limitation of $2,080 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 will not pay for outpatient physical therapy if you **are currently receiving any home health services**. Please understand you will be responsible for any balance incurred if you have not disclosed to us that you are also receiving services at home.

Are you currently receiving home health services? YES_____ NO _____
If yes, please inform the front desk immediately

Please sign below stating you have read and understood Medicare's Policies.

Signature:_____Date:_____

Depression Scale

INSTRUCTIONS: Choose the best answer for how you have felt *over the past week*.

***DISCLAIMER*: INSURANCE REQUIRES WE PROVIDE THIS FORM TO NEW PATIENTS. YOUR RESPONSES WILL REMAIN COMPLETELY CONFIDENTIAL. THANK YOU FOR YOUR COOPERATION.**

1. Are you basically satisfied with your life?	Yes	No
2. Have you dropped many of your activities and interests?	Yes	No
3. Do you feel that your life is empty?	Yes	No
4. Do you often get bored?	Yes	No
5. Are you in good spirits most of the time?	Yes	No
6. Are you afraid that something bad is going to happen to you?	Yes	No
7. Do you feel happy most of the time?	Yes	No
8. Do you often feel helpless?	Yes	No
9. Do you prefer to stay home rather than going out and doing new things?	Yes	No
10. Do you feel you have more problems with memory than most?	Yes	No
11. Do you think it is wonderful to be alive now?	Yes	No
12. Do you feel pretty worthless the way you are now?	Yes	No
13. Do you feel full of energy?	Yes	No
14. Do you feel that your situation is hopeless?	Yes	No
15. Do you think that most people are better off than you are?	Yes	No

Score Meaning:
Answers in **BOLD** indicate depression. Score 1 point for each bolded answer.
A score >5 points is suggestive of depression
A score ≥10 points is almost always indicative of depression
A score >5 points should warrant a follow-up comprehensive assessment

DRAC PHYSICAL THERAPY PRIVACY NOTICE

Patient Privacy:
DRAC Physical Therapy follows strict Federal and State Guidelines to maintain the confidentiality of your medical information.

How do we use medical information?
DRAC Physical Therapy uses your medical information to treat you, obtain payment for services, and to conduct normal business known as health care operations.
Treatment information received from another health care provider. We keep record of each visit. This may include an initial assessment, treatment plan and progress notes.
Payment: We document the services and supplies you receive at each visit so that you, your insurance company or another third party can pay us. We may tell your health plan about upcoming treatment or services that require their prior approval.
Health Care Operations: Medical information is used to improve the services we provide, to train staff and students, for business management, quality improvement and for customer service.
Other Services: We may also use information to recommend treatment alternatives, tell you about health benefits and services, to communicate with other healthcare providers or business associates for treatment, payment or healthcare operations. Business associates must follow our privacy rules.
Information we share: There are limited times when we are permitted or required to disclose medical information without your signed permission. These situations include:

- For public health activities such as tracking diseases or medical devices.
- To protect victims of abuse or neglect for federal and state health oversight activities such as fraud investigations.
- For judicial or administrative proceedings
- If required by law or for law enforcement
- To medical examiners and funeral directors
- For organ donation
- To avert serious threat to public health and safety
- For specialized government functions such as national security and intelligence.
- To workers compensation.
- To a correctional institution if you are an inmate
- For research following strict internal review to ensure protection of information.

DRAC PT Responsibilities:

- Maintain the privacy of your medical information
- Provide this notice of our duties and privacy practices
- Abide by the terms of the notice currently in effect.

Your Rights:

- Request that we restrict how we disclose your medical information. We may not be able to comply with all requests.
- Request that we use a specific telephone number or address to communicate with you.
- Inspect and copy your medical information. (Fee will apply)
- Request additional or corrections to your medical information.
- Receive an accounting of how your medical information was disclosed. (This excludes disclosures for treatment, payment, healthcare operations and some required disclosures, as well as disclosures you authorize)
- Obtain a paper copy of this notice

DRAC PT Contact: If you would like to exercise your rights or feel your privacy has been violated please contact our office at 781-326-8332