

## Rowe Physical Therapy & Associates

1400 Centre Street, Suite 104 ▪ Newton, MA 02459 ▪ Tel: 617-244-4462 ▪ Fax: 617-244-4435

### Welcome to Rowe Physical Therapy and Associates

We are happy you have chosen our office for your Physical or Occupational Therapy needs. We continuously strive to provide our patients with excellent service and quality care. Our commitment to your well-being and health care is something that we take to heart and always with your best interest first and foremost.

### About Rowe Physical Therapy

**Rowe Physical Therapy & Associates** is a team of caring and competent Physical and Occupational Therapists who have many years of experience and expertise in hands-on Manual Therapy. We take pride in our uniqueness as a holistic **Integrative Manual Therapy** practice that considers the importance of mind/ and body connections. We address our patients and clients as a whole with a total body approach, as needed, according to our comprehensive evaluation. We treat our clients with compassion and patience as we assist and facilitate the healing process and recovery towards optimal health. Our combination of **Manual Therapy** and **Individualized Exercise Programs** help you reach your predetermined goals that we set together.

We also offer a unique **Wellness Care Program** to keep you in the best possible shape for living a full life. (See link on website for more information)

### Your Commitment

The commitment to your Physical or Occupational Therapy program is critical to your success. Upon evaluation, we will recommend treatment with a **Plan of Care** that includes set goals. Consistency and compliance with your Plan of Care will insure reaching these goals. Your Therapist will always be available to answer any questions regarding your treatment and care.

We will give you a list of your scheduled appointments. If you should misplace this, please give us a call to review your appointment dates. We expect you to keep all your appointments, however should you need to cancel please note that **we require a 24-hour notice or a full fee charge** will be assessed. This is a strict policy that we adhere to.

### Insurance Coverage

If you have health insurance, our staff will contact your insurance company and verify your therapy benefits. We will provide you, to the best of our ability, what your co-pay, co-insurance, deductible etc. will be for each treatment, but we encourage you to also call your insurance company to find out your coverage and what your financial obligations may be. Our Front Desk Specialist can help you with any questions regarding your appointments, insurance, financial responsibilities or any other administrative issues.

We thank you for choosing **Rowe Physical Therapy & Associates** and we look forward to working with you and helping you to reach your optimal goals.

The Staff at Rowe Physical Therapy & Associates

[www.RowePT.com](http://www.RowePT.com)

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## PATIENT REGISTRATION

Today's Date \_\_\_\_\_ Auto Accident \_\_\_ Worker's Comp \_\_\_ Date of Injury \_\_\_\_\_

Name \_\_\_\_\_  
First MI Last

Address \_\_\_\_\_  
Street PO Box Apt #

Address \_\_\_\_\_  
City State Zip

Home Phone - - - - - Work Phone - - - - - Cell Phone - - - - -

SS# - - - - - Male or Female Marital Status M S D

DATE OF BIRTH: \_\_\_\_\_ E-Mail: \_\_\_\_\_

### Employer Information (Must complete for Worker's Comp Claims):

Employer \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

### Physician Information:

Referring Physician Name \_\_\_\_\_ PCP \_\_\_\_\_

Medicare Patients: Have you or are you currently receiving Home Health Care? Y \_\_\_ N \_\_\_

Have you had Physical Therapy elsewhere this year? Y \_\_\_ N \_\_\_ When & Where? \_\_\_\_\_

### MVA or Work Comp Claim Information:

Have you had Physical Therapy for this accident before? No \_\_\_ Yes \_\_\_ When & Where? \_\_\_\_\_

Claim Number \_\_\_\_\_ Insured Name \_\_\_\_\_

Insurance Company \_\_\_\_\_ Claims Adjuster \_\_\_\_\_ Phone \_\_\_\_\_

ATTORNEY: Name & telephone number \_\_\_\_\_

### Primary Health Insurance Information:

Insurance Name \_\_\_\_\_ Primary Insured Name \_\_\_\_\_

Insured Birth Date \_\_\_\_\_ Relationship to insured \_\_\_\_\_ Insured Phone # \_\_\_\_\_

Insured Address if Different from Patient:

Address \_\_\_\_\_  
Street City ST Zip

ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

### Secondary Health Insurance Information:

Insurance Name \_\_\_\_\_ Primary Insured Name \_\_\_\_\_

Insured Birth Date \_\_\_\_\_ Relationship to insured \_\_\_\_\_ Insured Phone # \_\_\_\_\_

ID Number \_\_\_\_\_  
Street City ST Zip  
Group Number \_\_\_\_\_

### Emergency Contact:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# \_\_\_\_\_

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## CONSENT TO TREATMENT

I hereby authorize the professional staff at **Rowe Physical Therapy, Inc.** to examine and treat me with Physical Therapy and/or Occupational Therapy for the injury I have been referred here for or referred myself to.

\_\_\_\_\_  
Patient Name (Printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Parent or Guardian (Printed)

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

## **ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO HEALTH PROVIDER**

Insurance Company/Companies Name(s) \_\_\_\_\_

**I hereby instruct the above named insurance company/companies to pay by check made out to and mailed directly to: *Rowe Physical Therapy, Inc.*** for professional or medical expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy. I understand that **Rowe Physical Therapy, Inc.** complies with HIPPA and will protect my Protected Health Information (PHI) and will use it as allowable by law in the treatment, billing and collection pertaining to my care until my case is closed and full payment is received. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney for the purpose of securing payment under this policy of insurance or to any Medical Provider associated with my case to effectively treat me. The authorization is in effect until 90 days from the date the last bill is collected.

**HIPPA REGULATIONS** A photocopy of this Assignment shall be considered effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance under the HIPPA guidelines.

\_\_\_\_\_  
Patient Name (Printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Parent or Guardian (Printed)

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

# Rowe Physical Therapy and Associates

## Confidential Patient Medical History

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Age: \_\_\_\_\_

Please describe your current health problem: \_\_\_\_\_

Please describe how and when your symptoms began: \_\_\_\_\_

Is your pain:

Constant 76-100%    Frequent 51-75%    Occasional 26-50%    Intermittent 25% or less

Indicate the intensity of your **pain at rest**:

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Indicate the intensity of your **pain with movement**:

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Your symptoms are worse in: Morning    Afternoon    Night

Symptoms increase: With Activity    Same at all times

**Please mark on the pictures where you have pain or other symptoms using the given symbols.**

Sharp pain xxx

Throbbing ooo

Dull Ache △

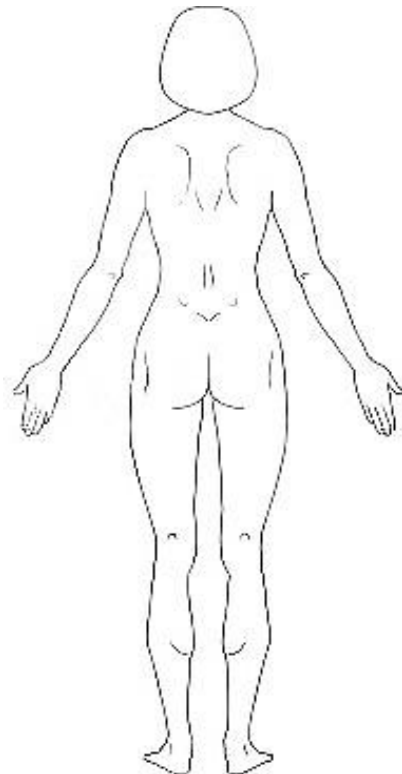
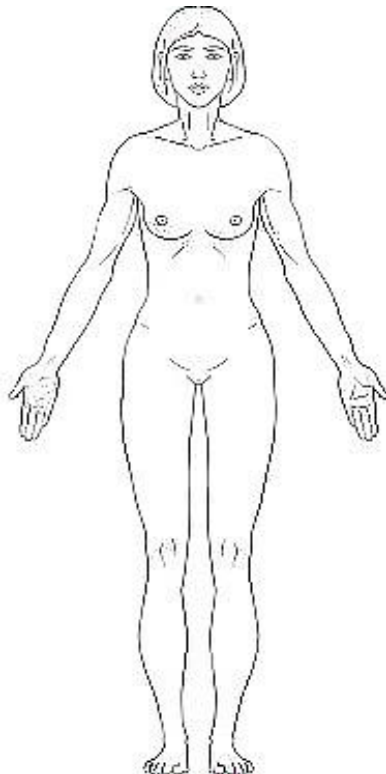
Shooting #

Burning \*\*\*

Numbness ☆

Other \_\_\_\_\_

No Pain



**What type of treatments have you tried for this problem? Indicate which if any have helped.**

- Physical Therapy/Occupational Therapy
- Yoga/Pilates
- Cortisone injections
- Surgery
- Chiropractor
- Acupuncture
- Pain medications. If yes, please indicate what you are taking: \_\_\_\_\_
- I have not been treated for this condition.
- Other \_\_\_\_\_

Occupation: \_\_\_\_\_ Has your work status changed because of this condition? Yes \_\_\_ No \_\_\_

**Please indicate any of the following conditions that you may have now or had in the past.**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Arthritis                 | <input type="checkbox"/> Sciatica            | <input type="checkbox"/> Lupus                      |
| <input type="checkbox"/> Rheumatoid                | <input type="checkbox"/> Neck Pain           | <input type="checkbox"/> TMJ                        |
| <input type="checkbox"/> Fibromyalgia              | <input type="checkbox"/> Jaw Pain            | <input type="checkbox"/> Neuropathy                 |
| <input type="checkbox"/> Chronic fatigue           | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Allergies                  |
| <input type="checkbox"/> Edema/Swelling            | <input type="checkbox"/> Hearing Loss        | <input type="checkbox"/> Abdominal Pain             |
| <input type="checkbox"/> Lymphedema                | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes                   |
| <input type="checkbox"/> Spinal Stenosis           | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Recent weight loss or gain |
| <input type="checkbox"/> Osteoporosis              | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Heartburn                  |
| <input type="checkbox"/> Osteopenia                | <input type="checkbox"/> Pacemaker           | <input type="checkbox"/> Cancer type: _____         |
| <input type="checkbox"/> Multiple Sclerosis        | <input type="checkbox"/> Anxiety/Stress      | <input type="checkbox"/> Raynaud's                  |
| <input type="checkbox"/> Low Back Pain             | <input type="checkbox"/> Depression          | <input type="checkbox"/> Complex Regional Pain/RSD  |
| <input type="checkbox"/> Muscle/Joint Pain         | <input type="checkbox"/> Sleep Problems      | <input type="checkbox"/> Thyroid problem            |
| <input type="checkbox"/> Fractures Location: _____ |  |   |

Please describe any other medical issues you have had that are not covered above.

\_\_\_\_\_

Please list any Hospitalizations and/or Surgeries.

\_\_\_\_\_

Please list any medications you are taking.

\_\_\_\_\_

Please list any other significant ailments or problems that have required medical treatment in the past.

\_\_\_\_\_

Do you exercise regularly? \_\_\_ Yes \_\_\_ No

What kind of exercise? \_\_\_\_\_ How long (minutes) \_\_\_\_\_ How often? \_\_\_\_\_

If you do not exercise, why? \_\_\_\_\_

Have you experienced any falls or been in a motor vehicle accident? Yes \_\_\_ No \_\_\_

If yes, please describe: \_\_\_\_\_

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## FINANCIAL POLICIES

Please take the time to carefully read the following policies. Your full understanding of these policies is important prior to treatment, so feel free to ask if you have any questions. We require your signature after you have read these policies:

### Payment Policy:

1. Payment is required at the time services are rendered. This includes your deductible, co-pay, co-insurance or full pay if you have no verified or authorized benefits from any insurance company. Payment can be made by credit card, check or cash. (\_\_\_)
2. If we agree to bill your insurance company this is provided as a service to you and in no way relieves you of your responsibility of any balance that we are unable to collect in a timely manner of 60 days from the initial claim sent to your insurance company. It is important to understand that the contract is between you and your insurance company and we are considered a third party. Every plan is different and it is up to you to know in advance what your plan will cover and what your deductible, co-insurance and co-pay are. Any information provided to us by the insurance company at the time of verification does not guarantee payment and the benefit is subject to the provision of your policy at the time when your insurance company processes your claim. You are ultimately responsible for the entire balance of your bill if we are unable to collect payment in a timely manner from your insurance company. (\_\_\_)
3. There will be a \$15 late payment fee after the initial bill period of 30 days if payment is not received by the 60 day billing cycle. Also, there will be an interest charge for each bill accrued every 30 days after the initial bill period in the amount of 1.5% as provided by state law. (\_\_\_)

### Returned Check Policy:

There is a \$25.00 service charge on any returned checks. Patients will issue a replacement check or advice if the returned check can be re-deposited. (\_\_\_)

### Cancellation Policy:

A twenty-four (24) hour notification of cancellation is required. Failure to abide by this policy will result in the full treatment fee being charged to you personally. Insurance companies are not responsible for this fee and will not reimburse the patient. Please be advised there is a telephone answering machine available for leaving any messages during non-office hours. (\_\_\_)

### Late For Appointment Policy:

If you arrive late for your scheduled appointment, you are responsible for paying for each 15 minute increment that you are late. We cannot bill your insurance company for this unused treatment time. (\_\_\_)

**Thank you in advance for your cooperation with the above policies.**

### *Acknowledgement*

I, the undersigned, have read, fully understand, and agree with Rowe Physical Therapy's Financial Policies. I have had the opportunity to ask questions regarding this policy. Upon request, a copy of this policy will be provided for my records.

\_\_\_\_\_  
*Print Patient's Name*

\_\_\_\_\_  
*Patient's or Policy Holder's Signature or Authorized Representative*

\_\_\_\_\_  
*Date*

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## NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice takes effect on April 14, 2003 and remains in effect until we replace it.

### **1. OUR PLEDGE REGARDING MEDICAL INFORMATION**

The privacy of your medical information is important to us. Medical information is broadly defined to include any information, oral or recorded, relating to the health of an individual, the health care provided to an individual, or payment for health care provided to an individual. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

### **2. OUR LEGAL DUTY**

#### **Law Requires Us to:**

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

#### **We Have the Right to:**

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

#### **Notice of Change to Privacy Practices:**

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

### **3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION**

The following section describes different ways that we use and disclose medical information. This process will occur very consciously to protect this private information as it may be transferred orally, or by means of an electronic medium. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by putting this revocation in writing.

**For Treatment:** We will use your medical information to provide you with medical treatment or services. We may disclose medical information about you to your doctors, nurses, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them and us in treating you.

**For Payment:** We may need to use and disclose your medical information for reimbursement from your insurance company or third party payer.

**For Health Care Operations:** We may use and disclose your medical information for Rowe Physical Therapy operations. This might include office communications involving scheduling and/or billing procedures, measuring and improving quality care, evaluating the performance of employees or conducting training programs.

**For Lawsuits:** As requested by you we may use and disclose your medical information to your attorney(s) to assist in your lawsuit proceedings.

#### **4. ADDITIONAL USES AND DISCLOSURES**

In addition to using and disclosing your medical information for treatment, payment, health care operations, and lawsuits we may use and disclose medical information for the following purposes.

**Notification:** Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location and general condition. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment.

**Court Orders and Judicial and Administrative Proceedings:** We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

**Public Health Activities:** As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

**Workers Compensation:** We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

**Health Oversight Activities:** We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

#### **5. YOUR INDIVIDUAL RIGHTS**

##### **You Have a Right to:**

1. Look at or get copies of your medical information.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we change your medical information. We may deny your request. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
5. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the Privacy Officer at your office.

#### **QUESTIONS AND COMPLAINTS**

If you have any questions about this notice, or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.