**THE IPSWICH CENTER**
**FOR PHYSICAL THERAPY**

**PATIENT INFORMATION**

Last Name: _____First: _____Middle_____

Address: _____
Street City State Zip
Home Phone: _____Work: _____Cell: _____

E-Mail Address: _____

Date of Birth: ____/____/____ Age: _____ Sex: ____ M ____ F Social Security #:_____

Employer/Job Title: _____

Emergency Contact: _____ Phone Number: _____

Primary Care Physician: _____
Name City/State Phone Number

Referring Practitioner: _____
Name City/State Phone Number

**HEALTH INSURANCE**

Health Insurance Carrier Name: _____

Name of Subscriber: _____ Relationship to Insured: _____

Have you obtained a referral: ____ Y ____N ***Obtaining a referral is the sole responsibility of the patient****

Is this injury the result of an auto or workers compensation accident: ____ Y ____ N

*The above information is true to the best of my knowledge. I understand that my insurance may not pay all my bills, and I may be responsible for payment, co-payments, deductibles, or co-insurance.*

Patient Signature: _____ Date:____/____/____

(over please)

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**PATIENT HISTORY SHEET**

1. Where is the location of the current problem? _____
2. How serious do you think the problem is? Mild _____ Moderate _____ Severe _____
3. How did you get the problem? _____
4. When did it occur? _____
5. Have you had surgery? _____
6. Did you see a doctor for the problem? ___ Y ___ N Doctor's Name:_____
7. Has your doctor given you a diagnosis? If so, what? _____
8. Were any diagnostic procedures performed (e.g. X-Ray, CAT Scan, MRI, etc.)?

   _____
9. Have you had it before? ____ Y ____ N If yes, when?_____
10. Please list any pertinent past medical history (e.g. any other condition which affects your ability to exercise or participate in general activities):
    Heart condition: _____
    Lung condition: _____
    Cancer: _____
    Diabetes: _____
    Other (e.g. past surgery or occurrences of affected side of the body) _____
    _____
11. What activities are limited by your injury? _____
12. Have you been seen at any other physical therapy establishment for this condition?

    ____ Y ____N If so, when? _____
13. Are you currently receiving any Home Health Care or VNA services of any kind? ____ Y ____ N
14. Is this injury the result of an Auto or Workers Compensation accident? ____ Y ____ N
15. Are you currently: Employed Full-time ____ Part-time ____ Retired ____ Student ____

    Not Employed ____ Homemaker ____ On Disability ____

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## CANCELLATION AND NO-SHOW POLICY

**Cancellation:** An unfulfilled appointment where the patient calls the office to notify the staff ahead of time.
**No-Show:** An unfulfilled appointment where the patient fails to notify the office and staff ahead of time.

The Ipswich Center books specific slots of time for you and for all of our patients allowing everyone to receive the utmost personal care and attention. Late cancellations and no-shows greatly impair our ability to provide the best care possible to our patients, slows each patient's rehabilitation progress, and eliminates a treatment appointment that could have been used by another patient.

The Ipswich Center requires patients to allow a courtesy of 24 hours notification for all cancellations. The Ipswich Center reserves the right to charge you $25.00 for a cancellation within two hours prior to your scheduled appointment time. The Ipswich Center reserves the right to charge you $50.00 for all no-show appointments as well as removing all future scheduled appointments and discharging you from our care. The Ipswich Center requests that you adhere to this policy so that we may offer readily available appointments to you and all our patients.

## NOTIFICATION OF RESPONSIBILITY FOR INSURANCE ELIGIBILITY AND BENEFITS

It is the responsibility of the patient or responsible party to confirm their insurance eligibility and benefits with their health insurance carrier. This includes understanding your co-payment, deductibles, co-insurance, visit limit, consecutive day limit, and/or any other limitations detailed in your health insurance policy.

You are responsible for contacting your insurance carrier to establish what your individual benefits are for services rendered to you or your dependents.

You are responsible to secure an insurance referral from your primary care physician, if necessary, in addition to a physician's script.

## Acknowledgement of Notice of Privacy Practices

"I hereby acknowledge that I received a copy of this practice's Notice of Privacy Practices. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed below. I further understand that the practice will offer me updates to this Notice of Privacy Practices should it be amended, modified, or changed in any way."

I HEREBY AGREE TO AND WILL UPHOLD THE POLICY STATED ABOVE

Patient Signature: _____ Date: ____/____/____
Patient (or Parent/Guardian, if patient is a minor)

HIPAA Officer 0 Eve Hamlin
*Policies updated 09/23/2016