

**DRAC Physical Therapy  
Patient Registration Form**

TODAY'S DATE: \_\_\_/\_\_\_/\_\_\_

**PATIENT INFORMATION**

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

Sex:  M  F Date of Birth: \_\_\_/\_\_\_/\_\_\_

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: \_\_\_\_\_

In Case of Emergency Call:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**INSURANCE INFORMATION**

PRIMARY Insurance: \_\_\_\_\_ ID #: \_\_\_\_\_

Group # (if applicable): \_\_\_\_\_ Policy Holder: \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_ SS#: \_\_\_-\_\_\_-\_\_\_ Relationship to Policy Holder: \_\_\_\_\_

SECONDARY Insurance: \_\_\_\_\_ ID #: \_\_\_\_\_

Group # (if applicable): \_\_\_\_\_ Policy Holder: \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_ SS#: \_\_\_-\_\_\_-\_\_\_ Relationship to Policy Holder: \_\_\_\_\_

\*Please let the receptionist know whether your injury is job related or motor vehicle related \*

**RESPONSIBLE PARTY STATEMENT**

AS THE RESPONSIBLE PARTY, I AGREE THAT ANY CHARGES NOT DIRECTLY PAID BY MY INSURANCE MAY BE MY RESPONSIBILITY.

Signature: \_\_\_\_\_ Today's Date: \_\_\_/\_\_\_/\_\_\_

Empty box for initials

INITIALS  
(For office use only)

# DRAC PHYSICAL THERAPY INTAKE QUESTIONNAIRE

**Referring Doctor:**

Name: \_\_\_\_\_

**Primary Care Physician: (If not the same as above)**

Name: \_\_\_\_\_

**How did you hear about us? (Check a box)**

Primary Care Physician

Specialist

Word of mouth

Friend

Other: \_\_\_\_\_

(Check Yes or No)

**HAVE YOU HAD PHYSICAL THERAPY YET THIS CALENDAR YEAR?**

Yes: \_\_\_\_\_

No: \_\_\_\_\_

**IS THIS INJURY THE RESULT OF A WORK RELATED ACCIDENT?**

Yes: \_\_\_\_\_

No: \_\_\_\_\_

If yes, do you have a claim on file? (See additional paperwork)

Yes: \_\_\_\_\_

No: \_\_\_\_\_

**IS THIS INJURY THE RESULT OF A MOTOR VEHICLE ACCIDENT?**

Yes: \_\_\_\_\_

No: \_\_\_\_\_

If yes, do you have a claim on file? (See additional paperwork)

Yes: \_\_\_\_\_

No: \_\_\_\_\_

**IS THIS INJURY THE RESULT OF A SLIP AND FALL?**

Yes: \_\_\_\_\_

No: \_\_\_\_\_

If yes, where did you fall? (At home, at a store, etc)

\_\_\_\_\_

**HAVE YOU HAD HOME PHYSICAL THERAPY OR VNA SERVICES?**

Yes: \_\_\_\_\_

No: \_\_\_\_\_



**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 \_\_\_\_\_

**NOTICE OF APPOINTMENT CANCELLATIONS:**

I understand that a twenty-four (24) hour notice must be given to DRAC PT to cancel an appointment, otherwise there will be a \$35.00 fee charged.

Your initials \_\_\_\_\_

**DEDUCTIBLE AND CO-INSURANCE AGREEMENTS:**

I hereby agree to pay all deductible and co-insurance payments as required by the policies of my insurance coverage. I further agree to pay these bills upon notification. Failure to reimburse balances owed in a timely manner, 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 delay payment, pend, or deny claims beyond 60 days of submission, I will be responsible for payment in full to DRAC PT within 10 days of 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 \_\_\_\_\_

**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.**

**SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_**

## 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, to obtain payment for services, and to conduct normal business known as health care operations.

**Treatment information received from another healthcare provider.** We keep record of each visit. This record 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 use or 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 that you authorize.)
- Obtain a paper copy of this notice.

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

**\*\*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:* \_\_\_\_\_