



Acknowledgement of Office Policies

The following are Bay State Physical Therapy and Milton Chiropractic & Rehabilitation's policies governing appointment scheduling, payment terms, and information releases. Please read carefully and be sure to ask questions you might have before signing the document.

Appointment Scheduling: We at Bay State Physical Therapy and Milton Chiropractic & Rehabilitation are glad to accept insurance assignment on your behalf in handling your personal injury or worker's compensation claim. However, in order to help ensure that your insurance company pays for the care you receive here, it is important that you adhere to the recommended care program. We require a 24 hour cancellation notice for all appointments. If you miss three (3) appointments in a three (3) week period without notifying Bay State (emergencies considered), you may be dismissed from care and your file may be closed.

Consent for Treatment: I, the undersigned, give Bay State Physical Therapy and/or Milton Chiropractic & Rehabilitation my permission to evaluate and treat my injury. I further understand that in the course of recommended treatment, condition may worsen on rare occasions. I further understand that no guarantee or promise has been made to me concerning the results of treatment. I further understand that the gym and/or pool areas are common areas accessed by patients, gym members and guests and as a result there may be incidental contact with personal health information.

Assignment of Payment: I hereby authorize my insurance company and/or my attorney to pay direct to Bay State Physical Therapy and/or Milton Chiropractic & Rehabilitation any monies due on my account for professional services rendered.

Acknowledgment and Understanding: It is further understood that I, the undersigned, agree to pay the full amount of the charges should my condition be such that it is not covered by my policy, or if, for any reason, the insurance company and/or my attorney refused to pay my balance at this office.

Private Health Insurance: I understand that I am responsible for whatever fees my insurance company does not pay on my claim. (Typically, this includes deductibles and/or co-payments).

Authorization to Release Information: I have read and fully understand Bay State Physical Therapy and/or Milton Chiropractic & Rehabilitation's Notice of Information Practices. I understand that Bay State Physical Therapy and/or Milton Chiropractic & Rehabilitation may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payments, understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operation if I notify the practice. I also understand that Bay State Physical Therapy and/or Milton Chiropractic & Rehabilitation will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

Patient Requests for Records: I instruct the release of all medical, hospital, or surgical records pertinent to my case, including but not limited to exams, special test, x-rays, or lab results to this office.

Ownership: I understand that Milton Chiropractic, Bay State Physical Therapy, Optimal Weight Loss, and Massage Works! Are all owned and operated by the same entity. I understand I have the option to seek any/all of the same services these clinics provide elsewhere.

I certify that I have read and understand all appointment and office policies listed above.

Patient Signature (Parent/Guardian of Minor): _____ Date: _____
Name (Please Print): _____ DOB: _____

Designate Individuals Authorization Form

I hereby authorize one or all of the designated parties listed below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Please give the name(s) of the individual(s) who you will allow to receive any part(s) of your health record.

Authorized Designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ DOB: _____

Patient Name

_____ Date: _____
Patient Signature (Parent/Guardian of Minor)

Medical History Form

Name: _____ DOB: ___/___/_____ Today's Date: ___/___/_____

Occupation: _____ Gender: _____ PCP: _____

Referring Physician (MD): _____ Next appointment w/ referring MD: ___/___/_____

Please answer the following questions:

What injury or condition brings you here today? _____

When did you first notice your condition (date of onset)? _____

How did this injury occur? _____

Is your condition due to a motor vehicle accident? Yes No If yes, date of accident? _____

Have you had any falls in the past 12 months? Yes No If yes, how many times? _____

Did the fall(s) result in injury? Yes No If yes, please describe: _____

Please describe above: _____

Are you seeing (or have you been seen by) any other specialists for your current condition (e.g.: doctor, psychologist, chiropractor, physical therapist, etc.)? Please list: _____

Have you been treated by another physical therapist/chiropractor in the past for this or any other condition?
 Yes No

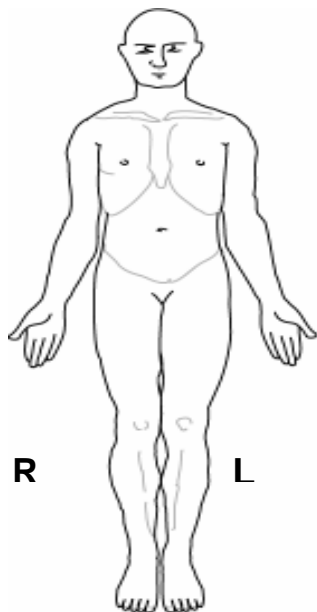
If Yes, by whom/when? _____

What tests have you had for this condition? X-ray MRI CT scan Other: _____

Please mark where you have symptoms on the picture below.

Sharp Pain: /////
 Achy Pain: ^^^
 Burning Pain: XXXXX
 Numbness: 0000

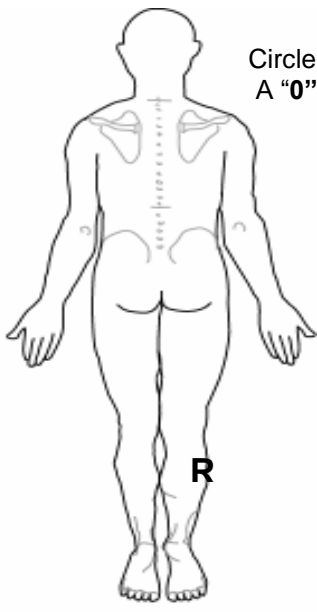
Circle the number corresponding with the intensity of your symptoms.
 A "0" = No Pain where as a "10" = most severe pain imaginable.



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Location: _____ 0 1 2 3 4 5 6 7 8 9 10

Location: _____ 0 1 2 3 4 5 6 7 8 9 10

Location: _____ 0 1 2 3 4 5 6 7 8 9 10

Location: _____ 0 1 2 3 4 5 6 7 8 9 10

Since this condition began your symptoms have: decreased not changed increased

Your symptoms are worse in the: morning afternoon night

same all day

What are your goals for treatment? _____

Please list past surgeries/conditions/hospitalizations (or you may attach a separate list):

_____ / /

_____ / /

_____ / /

Please list all medications, dosage, frequency and route (or you may attach a separate list):

Name: _____ Dosage: _____ Frequency: _____ Route: _____

Name: _____ Dosage: _____ Frequency: _____ Route: _____

Name: _____ Dosage: _____ Frequency: _____ Route: _____

Have you ever been diagnosed and/or treated for any of the following conditions (circle all that apply):

CONSTITUTIONAL

Weight Loss

Fatigue

Fever

EYES

Glasses/Contacts

Eye Pain

Double Vision

Cataracts

CARDIOVASCULAR

Murmur

Chest Pain

Palpitations

Fainting/Spells

Short of Breath

Difficulty Lying Flat

Swelling in Ankles

Pacemaker/Defibrillator

ENDOCRINE

Loss of Hair

Heat Intolerance

Cold Intolerance

PSYCHIATRIC

Anxiety

Depression

Mood Swings

Difficulty Sleeping

RESPIRATORY

Cough

Coughing Blood

Wheezing

Chills

GASTROINTEST

Heartburn/Reflux

Nausea/Vomiting

Constipation

Change Bowel Mvts

Diarrhea

Jaundice

Abdominal Pain

Black/Bloody Bowel Mvts

GENITOURINARY

Burning/Frequency

Nighttime

Blood in Urine

Erectile Dysfunction

Bladder Leakage

Abnormal Leakage

ALLERGIC

Hives/Eczema

Hay Fever

HEMATOLOGY/LYMPH

Bruise Easily

Gums Bleed Easily

Enlarged Glands

MUSCLE/BONE

Joint Pain/Swelling

Stiffness

Muscle Pain

Bone Pain

SKIN

Rashes/Sores

Lesions

Itching/Burning

NEUROLOGICAL

Loss of Strength

Numbness

Headaches

Tremors

Memory Loss

FEMALES ONLY

Age Onset of

Periods _____

Periods Regular?

Yes _____ No _____

Age Onset of

Menopause _____

Number of Pregnancies _____

Please list any allergies that you have (For example: medications, latex, food, bee stings): _____

Is there any additional information? _____

The above information is true to the best of my knowledge:

Signature (Parent/Guardian of Minor): _____ DOB: ___/___/___ Date: ___/___/___