Patient First Name: _____ **Patient Last Name:** _____

Sex(*for insurance purposes*)**: M / F**

Date of Birth: _____/_____/_____

Pronouns: _____

Email(*Used for billing and appointment reminders*)**:** _____

Home Phone: _____

Mobile: _____

Patient's Street Address: _____

City/ State/Zip: _____

How did you hear about Boston Physical Therapy & Wellness?

Primary Personal Health Insurance Carrier:_____

Member ID & Group# :_____ **GRP#:**_____

Secondary Health Insurance Carrier(If applicable)**:**_____

Member ID:_____

Subscriber Name and DOB(If other than self)**:**_____

Subscriber's Sex(*for insurance purposes*)**: M / F**

Subscriber's Relationship to patient:_____

Subscriber's Street Address(*If different from patient's*)**:**_____

Subscriber's City/ State/Zip: _____

Primary Care Physician *(Name and Location)***:**_____

Referring Physician *(Name and Location)***:**_____

Emergency Contact

Name:_____

Phone Number:_____

Relationship to Patient:_____

Present Condition

What is the main cause/reason for today's visit?_____

When did this begin? *(MM/DD/YY)***:**_____

Have you had PT for this in the last 2 years? Y / N How many visits?_____

Please list all medications you are currently taking:_____

_____

Past Medical History

Please list all past surgeries:_____

_____

_____

Do you have a history of falls? Y / N If yes, when was your last fall?_____

Are there any other health conditions we should know about? Y / N

If yes, please disclose:_____

_____

_____

Assignment of Benefits

I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID
DIRECTLY TO BOSTON PHYSICAL THERAPY & WELLNESS AND I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES. I ALSO AUTHORIZE BOSTON PHYSICAL THERAPY & WELLNESS TO RELEASE ANY INFORMATION TO PROCESS THIS CLAIM.

Patient/Guardian (If under 18yo.) **Signature:**_____ **Date:**_____

Print Name: _____

Consent to Treat

I, THE UNDERSIGNED, VOLUNTARILY AUTHORIZE BOSTON PHYSICAL THERAPY & WELLNESS TO ADMINISTER PHYSICAL THERAPY THAT
IS NECESSARY AS APPROPRIATE IN THE OPINION OF THE REFERRING
PHYSICIAN AND/OR THE ALLIED HEALTH PERSONAL. PHYSICAL THERAPY IS NOT AN EXACT SCIENCE AND NO GUARANTEE HAS
BEEN MADE TO THE RESULT OF ANY TREATMENT ADMINISTERED. BY SIGNING THIS, I ACKNOWLEDGE RECEIPT OF THE NOTICE OF INFORMATION PRACTICES OF BOSTON PHYSICAL THERAPY & WELLNESS. I ALSO ACKNOWLEDGE I HAVE READ THE CLINIC POLICIES POSTED AT THE FRONT DESK
Patient/Guardian (If under 18yo.) **Signature:**_____ **Date:**_____

Print Name: _____

IMPORTANT RULES, POLICIES & RELEASE OF LIABILITY:

1. Late Policy: If I'm late more than 10-minutes to my appointment, I may be rescheduled or asked to wait for the next available open time slot.
2. 24 hour advance notice is required for changes to my appointment otherwise a $75.00 fee may apply.
3. Co-pays and/or deductibles are due prior to treatment starts.
4. Not showing for an appointment without notice (or less than 24 hours in advance) will result in a $75.00 fee added to my account.
5. Cell phones must be shut OFF or silent.
6. Children requiring supervision are NOT allowed to attend sessions with you without prior authorization.
7. If you are experiencing any financial hardship, please notify us immediately so we can create a payment program that is feasible.
8. If for any reason, you are NOT satisfied with the care received, please call us at 781-874-9294.
9. I have read and agree to the policies above.

Release from Liability Disclaimer: I fully understand and acknowledge that (a) the activities in which I will engage as part of the treatment provided by Boston Physical Therapy & Wellness and the physical therapy activities and equipment I may use as a part of that treatment have inherent risks, dangers, and hazards and such exists in my use of any equipment and my participation in these activities; (b) my participation in such activities and/or use of such equipment may result in injury or illness including, but not limited to bodily injury, disease, strains, fractures, partial and/or total paralysis, death or other ailments that, could cause serious disability; (c) these risks and dangers may be caused by the negligence of the representatives or employees of Boston Physical Therapy & Wellness, and any other entity, person, or associate, the negligence of the participants, the negligence of others, accidents, breaches of contract, or other causes. By my participation in these activities and for use of equipment, I hereby assume all risks and dangers and all responsibility for any losses and/or damages whether caused in whole or in part by the negligence or the conduct of the representatives or employees of Boston Physical Therapy & Wellness, or by any other person. I, on behalf of myself, my personal representatives and my heirs, hereby voluntarily agree to release, waive, discharge, hold harmless, defend, and indemnify Boston Physical Therapy & Wellness and their representatives, employees, and assigns from any and all claims, actions or losses for bodily injury, property damage, wrongful death, loss of services or otherwise which may arise out of my use of any equipment or participation in these activities. I specifically understand that I am releasing, discharging, and waiving any claims or actions that I may have presently or in the future for the negligent acts or other conduct by the representatives or employees of Boston Physical Therapy & Wellness By SIGNING BELOW YOU ARE CONFIRMING THAT, "I HAVE READ THE ABOVE WAIVER AND RELEASE AND BY SIGNING IT AGREE. IT IS MY INTENTION TO EXEMPT AND RELIEVE BOSTON PHYSICAL THERAPY & WELLNESS FROM LIABILITY FOR PERSONAL INJURY, PROPERTY DAMAGE OR WRONGFUL DEATH CAUSED BY NEGLIGENCE OR ANY OTHER CAUSE."

Patient/Guardian (If under 18yo.) **Signature:**_____ **Date:**_____

Print Name: _____