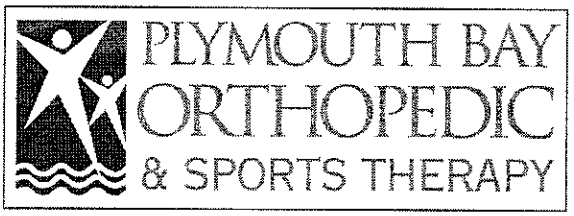


Welcome to Plymouth Bay Orthopedic and Sports Therapy! We are here to help you return to your peak functional performance, either from a simple sprain or joint replacement. For over 25 years, we have been providing top quality care to residents of the South Shore area.

We would like to explain how our therapy facility works.

A referral from your physician will be required to ensure it that it addresses your medical issue. Sometimes, you will be directed to therapy for multiple medical issues. Unfortunately, because of insurance restrictions, we are able to address only one problem at a time

You will then be scheduled an appointment to be evaluated by a therapist, either a physical or occupational therapist. An exercise therapy plan will be established based on your individual needs. This plan will be implemented by your team, the therapist, therapy assistant and therapy aide. Each professional has a specific role in your care. Heat, cold, exercises, mobilizations and functional activities will be provided by the members of your team.

After a period of time, you will be scheduled for a "re-evaluation" by the evaluating therapist. The therapist will review your progress and update your therapy plan. Recommendations will be made to your physician. At time of discharge, you will be instructed in a home program to optimize function with the goal of returning to all of your activities.

If you have any questions regarding your care, please ask to speak to your evaluating physical or occupational therapist. We hope to make your experience at PBOST a positive one!!!!

PLYMOUTH BAY ORTHOPEDIC & SPORTS THERAPY

95 Tremont Street, Ste 20, Duxbury MA 02332

PATIENT INFORMATION

Last Name _____ First Name _____

Social Security # _____ DOB _____ ☐ Male ☐ Female

Marital Status ☐ Married ☐ Single ☐ Widowed Are you a full time student? ☐ YES ☐ NO

Address _____ City _____ State _____ Zip _____

Home Phone ( ) _____ Cell Phone ( ) _____ Work Phone ( ) _____

Email Address: _____

Employer _____ Occupation _____

Emergency Contact _____ Relationship _____ Phone # ( ) _____

Primary Care Physician _____ Phone ( ) _____

Referring Physician _____ Phone ( ) _____

GUARANTOR INFORMATION (Responsible Party if under 18)

Last Name _____ First Name _____

Social Security # _____ DOB _____ Relationship To Patient ☐ Parent ☐ Guardian

Address _____ City _____ State _____ Zip _____

Home Phone ( ) _____ Cell Phone ( ) _____ Work Phone ( ) _____

Employer _____ Work Phone ( ) _____

INSURANCE INFORMATION

Primary Insurance _____ ID# _____

Subscriber Name _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child

Subscriber DOB (required) _____ Address of Insured (if different than Patient Address):

_____

_____

Secondary Insurance _____ ID# _____

Subscriber Name _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child

Subscriber DOB (required) _____ Address of Insured (if different than Patient Address):

_____

_____

Is this a School Injury/Accident? ☐ YES ☐ NO **Date of Injury** _____

Is this a workers' compensation accident? ☐ YES ☐ NO **Date of Injury** _____

Is this a motor vehicle accident? ☐ YES ☐ NO **Date of Injury** _____

I certify that the information listed above is complete and accurate to the best of my knowledge.

_____ _____

Patient/Parent/Guardian Signature Date

PLYMOUTH BAY ORTHOPEDIC & SPORTS THERAPY

PATIENT MEDICAL HISTORY

Patient Name: _____ DOB: _____

Reason we are seeing you today? _____ Date of Injury _____
(required for fractures/sprains/injuries)

Describe your problem/complaint and how it happened: _____

_____

Previous Therapy/Treatment for CURRENT problem? ☐ YES ☐ NO Date(s) of treatment(s): _____

Next Follow Up Appointment with your physician? _____

Have you had Outpatient Therapy this year? ☐ YES ☐ NO

IF YES – specify dates of treatment: _____

Are you *currently* receiving HOME SERVICES of ANY KIND? ☐ YES ☐ NO From Where: _____

Please indicate if you have had any of the following:

__ Allergies
__ Asthma
__ Anemia
__ Arthritis/Joint Pain
__ Blurred Vision
__ Breathing Problems
__ Cancer, Type _____
__ Chest Pain
__ Clotting/Bleeding Problems
__ Diabetes
__ Depression
__ Dizziness/Fainting
__ DVT/Blood Clots/Phlebitis
__ Emphysema
__ Fevers
__ Fractures/Broken Bones
__ High Cholesterol
__ Gout
__ HYT Disease
__ Headaches
__ Hearing Loss
__ Hepatitis
__ Heart Disease/Attack
__ High Blood Pressure
__ Kidney/Urinary Problems
__ Lyme Disease
__ Memory Loss
__ Neck or Back Problems
__ Osteoporosis
__ Rashes
__ Seizures
__ Stroke/CVA
__ Swelling of Arms/Legs
__ Thyroid Disease
__ Tuberculosis
__ Ulcers/Reflux
__ Unplanned Weight Loss
-- Other _____

Current Medications

Be sure to include all Medicines and Vitamins

Name of Medication	Dosage	Frequency	Indicate by Mouth or otherwise	Prescription	Over The Counter	Vitamins And Herbals
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐

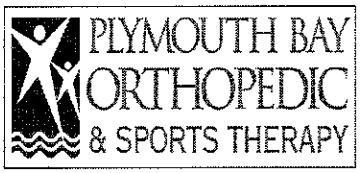
List all operations – including dates:

Name of Operation	Date of Operation

I certify that the information listed above is complete and accurate to the best of my knowledge.

_____ _____
Patient/Guardian Signature Date

df 03/2013



95 Tremont Street, Ste 20, Duxbury MA 02332

CONSENT FOR TREATMENT

Patient Name: _____ DOB: _____

I hereby request and consent to Plymouth Bay Orthopedic & Sports Therapy to perform rehabilitative treatment and care as prescribed by my physician and/or recommended by my physical/occupational therapist.

I understand and am informed that, as in the practice of medicine, physical/occupational therapy may have some risks. I understand that I have the right to ask about these risks and have my questions answered about my interventions or treatment for my condition.

I have carefully read and fully understand this Informed Consent Form and will have the opportunity to discuss my condition with the treating physical/occupational therapist.

I consent and authorize Plymouth Bay Orthopedic & Sports Therapy to administer treatment under the direction and supervision of the physical/occupational therapist.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Legal Guardian Date

_____ _____
Print Name of Parent/Legal Guardian Relationship to Patient

PLYMOUTH BAY ORTHOPEDIC & SPORTS THERAPY

PATIENT RESPONSIBILITIES – PLEASE READ AND SIGN

Patient Name: _____ Patient DOB: _____

- **Referrals/Prior Approvals (if applicable):** I understand my insurance company will not reimburse for the cost of any service without a referral/prior approval. I understand I am responsible for payment of the office visit charge or any other charges I may incur without a referral/prior approval.
- **Co-pay (if applicable):** I understand that I am responsible to pay a copayment for each visit. I understand that this is an agreement that I have with my insurance company. I understand that my copayment amount is due at the time of each visit.
- **Deductible (if applicable):** I understand that I have a calendar year deductible for outpatient therapy as outlined in my insurance policy. I understand that I am responsible for payment of any balance that has been applied to my deductible by my insurance company.
- **Co-Insurance (if applicable):** I understand that I have a co-insurance responsibility as outlined in my insurance policy. I understand that I am responsible for payment of any co-insurance balance assessed by my insurance company.
- **Authorization to Pay Benefits to the Provider:** I hereby authorize payment directly to the provider for medical benefits otherwise payable to me for services as described, realizing that I am responsible to pay for all non-covered services.
- **Termination of Insurance (if applicable):** I understand that in the event my insurance policy is terminated or cancelled, I am responsible for any and all charges incurred after the termination/cancellation date. I understand that it is my responsibility to notify the office of any changes in insurance coverage or lapse of insurance benefits during treatment. In the event there is a change/lapse in benefits, I understand that I will be responsible for payment for any non-covered services.
- **Workers' Compensation Information (if applicable):** I understand that it is my responsibility to provide all workers' compensation billing information at the time of the initial visit. I realize that without this information, I will be responsible for any charges incurred at the time of the visit. I understand that my health insurance information will be provided and benefits will be utilized in the event that my workers' compensation claim is denied.
- **Motor Vehicle Information (if applicable):** I understand that it is my responsibility to provide all claim information associated with my motor vehicle accident at the time of the initial visit. I realize that without this information, I am responsible for any charges incurred at the time of the visit. I understand that my health insurance information will be provided and benefits will be utilized in the event that my PIP is exhausted.
- **Durable Medical Equipment (if applicable):** I understand that DME is a service completely separate from traditional office visits and medical treatment. An additional co-insurance or deductible amount may be applied depending on your benefit plan specifics. Any and all deductible and or coinsurance amounts applied are a result of an agreement that you have with your insurance company and are your responsibility to pay. If any additional amount is due a separate statement will be mailed to you after your insurance company has processed the claim.
- **Refunds (if applicable):** I understand that in the event I am due a refund we will reimburse you through a check payment after all your visits have been processed by your insurance.
- **Cancellations/No Shows:** *In order to give all our patients the time and care they need for each treatment, we must follow the schedule. Please be on time for all appointments, and call ahead if you need to cancel an appointment. Consistent lateness and/or missed appointments will result in cancellation of treatment.*

I understand there is no guarantee of insurance coverage or benefit until my insurance receives and processes my visits.

If you have any questions regarding your insurance please call the customer service number located on the back of your insurance card.

Please notify us of any changes with your insurance status during treatment. Thank you.

I have read and understand all of the preceding information and certify the information provided is true and correct to the best of my knowledge.

_____ _____

Signature Date

_____ _____

Parent/Guardian Signature Date