GLYNN
PHYSICAL THERAPY

Date

PATIENT INFORMATION

Last Name_____ First Name_____ MI ____

DOB_____ Age _____ Address _____
MM / DD / YYYY

City _____ State _____ Zip _____

Home Phone _____ Cell _____ Email _____

Primary Care Physician_____ Referring Physician _____

Diagnosis_____ How did you hear about us? _____

Emergency Contact Name/Relationship_____ Phone # _____

PRIMARY INSURANCE

Carrier Name_____

Policy ID# _____

Policy Holder's Name _____

Policy Holder's DOB _____

Relationship to Patient _____

SECONDARY INSURANCE

Carrier Name_____

Policy ID# _____

Policy Holder's Name _____

Policy Holder's DOB _____

Relationship to Patient _____

MEDICARE PATIENTS ONLY

Have you received physical therapy or speech services within the year? ☐Yes ☐No

_____ _____
Patient/Guarantor/Guardian Signature Date

114 Waltham Street | Suite G-4 | Lexington, MA 02421 | **T** 781.862.0200 | **F** 781.862.0600
info@GlynnPT.com | **www.GlynnPT.com**

Please check if you have had problems with or been treated for any of the following:	
☐ High Blood Pressure	☐ Tuberculosis
☐ Heart Problems	☐ Repeated Infections
☐ Lung Problem	☐ Cancer
☐ Kidney Problems	☐ Osteoporosis
☐ Head Injury	☐ Circulation or Vascular Problems
☐ Stroke/Neurological Problems	☐ Broken Bones (Fracture)
☐ Liver Problems	☐ Arthritis
☐ Thyroid Problems	☐ Ulcer/Stomach Problems
☐ Blood Disorder	☐ Prostate Disease
☐ Diabetes (High Blood Sugar)	☐ Pelvic Inflammatory Disease
☐ Low Blood Sugar	☐ Endometriosis
☐ Seizures	☐ Have you had a complicated pregnancy/delivery?
Have you recently had:	
☐ Unexpected weight loss or gain	☐ Difficulty walking
☐ Unexplained Fever, Chills, or Sweats	☐ Loss of balance
☐ Pain at night	☐ Heart palpitations
☐ Fatigue/Tiredness or Malaise	☐ Shortness of breath
☐ Difficulty Sleeping	☐ Chest pain
☐ Joint pain and/or Swelling	☐ Difficulty swallowing
☐ Urinary or Bowel Problems	☐ New onset of headaches
☐ Nausea & Vomiting	☐ Visual problems
☐ Numbness or Tingling	☐ Hearing problems
☐ Weakness in your arms or legs	☐ Hoarseness
☐ Swelling of the ankles or legs	☐ Cough
☐ Coordination problems	☐ Dizziness or loss of consciousness
☐ A fall in the last 12 months	☐ A fear of falling
Do you:	
☐ Smoke	☐ Prior surgeries, or hospitalizations [please list]:
☐ Have a significant family history of cardiopulmonary illness or disease	

Current medications [please list name, dosage & frequency]: _____

_____

_____

Have you received physical therapy before? If so, what have you found helpful, or not helpful?

_____

_____

What is your goal[s] for physical therapy? _____

_____

NOTICE OF PRIVACY PRACTICES

I have received, and been given a chance to review the Glynn Physical Therapy LLC"Notice of Privacy Practices". I understand that this documents outlines the use and disclosure of my personal health information as well as my rights as a patient. I understand that Glynn Physical Therapy LLC 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 payment. I understand that if I notify the practice, I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations.

I HAVE READ AND UNDERSTAND THE ABOVE NOTICE OF PRIVACY PRACTICES

_____
Please Initial

ASSIGNMENT OF BENEFITS

I do hereby assign all medical benefits of which I am entitled to Glynn Physical Therapy LLC in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by said insurance and I agree to pay my deductible, my co-payment, and any adjustments not reimbursed by my insurance company. I understand that I am responsible for knowing and meeting the requirements of my insurance plan. I also understand that co-payments are due at the time of service and payment of any deductibles or coinsurances are my responsibility as indicated in my contract with my insurance carrier. Any portions of these charges not covered by my insurer must be paid by me.

I hereby authorize Glynn Physical Therapy LLC to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Glynn Physical Therapy LLC directly for services rendered to me or my dependents.

I HAVE READ AND UNDERSTAND THE ABOVE NOTICE OF ASSIGNMENT OF BENEFITS

_____
Please Initial

AUTHORIZATION FOR RELEASE OF INFORMATION

I understand that as part of my physical therapy treatment, Glynn Physical Therapy LLC, will develop and maintain records containing my health care information. These records will include health history, symptoms, test results, diagnoses, treatments, and claims and payment history.

I hereby authorize Glynn Physical Therapy LLC and my therapist to release and discuss health care information contained in my physical therapy record to and with professionals involved in my rehabilitative/physical therapy program. I also authorize the release of my health care information to any institution that through an insurance program or otherwise is paying for part of all of the costs of my physical therapy program. Authorization includes the release or reports as well as discussion or my health care information.

_____ _____

Patient Signature (or responsible party) Date

GLYNN
PHYSICAL THERAPY

CONSENT TO TREATMENT

The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation and subsequent intervention. Interventions may include manual techniques, exercises, modalities, and physical agents. I understand and am informed that as with the practice of medicine, physical therapy may carry some risks. These risks may include an increase or worsening of symptoms or aggravation of my existing injury. I understand that my physical therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. If I do not wish to participate in any aspects of the proposed therapy program, I will discuss my concerns with the physical therapist. I understand that I can terminate my treatment at any point.

Patient Agreement

1) I agree that I am responsible for understanding my insurance benefits and eligibility. If my insurance company requires a referral, prescription, or pre-authorization, I am responsible for obtaining it.

2) I will contact my physician for an updated prescription/order for PT and will follow-up for referrals as needed.

3) I agree to pay any outstanding co-payments, co-insurances, or deductibles required by my insurance company at the time of service.

4) I agree to provide 24 hours notice before cancelling a visit.

_____ _____

Signature of Patient/Legal Guardian Date

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