Hardy Physical Therapy Rehabilitation Services, Inc.

112 Main St. Northborough, MA 01532 (508) 393-7298
205 Washington St. Hudson, MA 01749 (978) 562-3114

For Therapist Use Only:
Rx:
Dx:
Complexity:

Patient Information

Today's Date: ____________________________________

Full Name ____

Address ____
Street City State Zip Code

Home Phone ________________________ Cell _______________________ Work __________________________

Would you like to receive appointment reminders via cell phone text or email? Text: Y____ N____ E-Mail: Y____ N____

E-Mail (Optional – Only If You Would Like To Receive Appointment Reminders via E-Mail) ______________________

Date of Birth _____/_____/__________ Sex M_____ F _____ SSN ____

Employer ____
Name Address

General Information

Date of Injury _________________________________ Date of Surgery _________________________________

Brief Description of Pain/Injury ____

Primary Care Physician ____ Phone _____________________________

Address ____ Last MD visit _____________________

Referring Physician ____ Phone ______________________________

Address ____ Last MD visit _____________________

Have you been treated elsewhere for this condition? Y _____ N _____

If yes please state where and for how long ____

Have you had Physical Therapy in the past 12 months? Y _____ N _____

If yes please state where and for how long ____

Is this injury a result of a Motor Vehicle Accident? Y _____ N _____ Work Related Accident? Y ______ N ______

Insurance Information

Name of Medical Insurance ____ Policy/ID # __________________

Subscriber's Name ___________________________________ Subscriber's Employer ___________________________

Motor Vehicle Accident? Y _____ N _____ If yes complete Date of Injury ________________________________

Insurance Company ______________________________________ Claim Number _____________________________

Workers Compensation? Y _____ N _____ If yes complete Date of Injury ________________________________

Insurance Company ____ Claim Number ______________________________

Contact Person _______________________________________ Phone Number __________________________________

Hardy Physical Therapy Rehabilitation Services, Inc.

112 Main St. Northborough, MA 01532 (508) 393-7298
205 Washington St. Hudson, MA 01749 (978) 562-3114

Please read the following carefully, initial each section, and sign below where indicated

Consent to treat and/or Disclose General Health Information

By my signature below, I hereby consent and give permission to **Hardy Physical Therapy** to administer Physical Therapy evaluation and treatment. I also give consent for **Hardy Physical Therapy** to seek payment from insurers and/or third parties for treatment and services rendered. I authorize **Hardy Physical Therapy** to disclose or release any medical information to insurers and/or third parties necessary for payment or processing of claims. Lastly I hereby authorize **Hardy Physical Therapy** to obtain any and all medical records necessary to aid in evaluation and treatment.

Initials ________

Co-payments / Co-Insurances / Deductibles

I understand that I am responsible for and agree to pay to **Hardy Physical Therapy** all co-payments, co-insurance, or deductibles as determined by my insurance company. Payment is due at the time of each visit and must be paid in full by the time of last visit. In the event that my deductible is not determined until an Explanation of Benefits is received from my insurance company, I understand a statement will be billed by mail and payment is due upon receipt. I understand that payments not received within 15 business days will be subject to a **$15 Late Fee.**

Initials ________

Cancellation and No-Show Policy

Appointments must be cancelled a minimum of 24 hours in advance. I understand that if I fail to cancel an appointment without sufficient notice **OR** if I fail to show up for a scheduled appointment I will be charged **$25.** I understand that if I do not show for more than 2 consecutive appointments I may be discharged from therapy and unable to make further appointments.

Initials ________

Insurance Benefits and Referrals

I understand that it is my responsibility to verify Physical Therapy coverage and benefits with my insurance company. If my insurance company requires a referral or prescription I am responsible to provide this prior to or at the time of the initial visit. I will also provide further referrals or prescriptions, as necessary, for the duration of treatment. I am responsible for awareness regarding Physical Therapy benefits including visits allowed and treatment end dates. I understand that I am financially responsible for all treatment and charges beyond authorized visits or end dates. I understand that if my health insurance changes and I do not inform **Hardy Physical Therapy** of these changes, I will be financially responsible for any and all treatment and charges not covered.

Initials ________

By initialing all sections above I agree that I have read, understand, and agree to all terms and policies.