JumpStart Physical Therapy

I ACKNOWLEDGE THAT IT IS MY RESPONSIBILITY TO VERIFY AND UNDERSTAND WHAT MY CONTRACTED PHYSICAL THERAPY BENEFIT IS WITH MY HEALTH INSURANCE PROVIDER.

AUTHORIZATION TO MAKE DIRECT PAYMENT FOR MEDICAL SERVICES:
I hereby authorize that my health insurance company (ies) will be responsible for making payments directly to JumpStart Physical Therapy, Inc. for all services rendered to me.

PATIENT PAYMENT RESPONSIBILITY:
I understand that should my health plan require me to pay a co-pay per physical therapy visit, then I shall make this payment at the time the service is rendered.

I understand that I am personally responsible for paying any deductible, coinsurance, or unpaid portion of my bill directly to JumpStart Physical therapy upon request. I agree to pay an interest fee of 1.5% per month on any outstanding balance on my account.

Sick Policy: With respect to our therapists and all of our patients, please do not bring your child/yourself to the therapy appointment if they/you are in poor health.

SIBLING POLICY
For the safety of all patients and to prevent treatment interruptions we kindly ask that all siblings/children other than the patient remain in the waiting room.

CONSENT TO PHYSICAL THERAPY TREATMENT (PHYSICAL THERAPY FOR MYSELF)
I hereby authorize the staff of JumpStart to evaluate and administer physical therapy care to me.

CONSENT TO PHYSICAL THERAPY TREATMENT (OF A MINOR CHILD)
I hereby attest that I am the legal custodian of the minor child being treated for physical therapy and authorize the staff of JumpStart Physical Therapy to administer care as they deem necessary to my child.

CANCELLATION / NO SHOW POLICY:

Twenty-four (24) hour notice must be given to JumpStart to cancel an appointment. Should you cancel an appointment within 24 hours or fail to appear for a scheduled appointment without notice, a $50.00 late cancellation/no show fee will be assessed.

MEDICARE:

If you have MEDICARE, you are required to provide the physical therapist with a list of any medications (prescriptions, OTC, herbal supplements) you are on, including the medicine name, dosage, frequency and how it is administered (e.g. orally or injections) at the time of your initial evaluation

If you have had any home health care recently, you must be completely discharged from home health care before you can begin outpatient physical therapy. please bring the discharge papers with you or you can have them faxed to 781 349 8235.

If you have recently **applied** to get Medicare it is very important that you notify JumpStart ASAP.

I have read, understand and agree to the above terms and conditions. My signature acknowledges my agreement and full understanding of the above information.

_____
(Please print patient name)

Signature: _____ Date: _____

Patient Health Record

Who is your Primary Care Physician? _____

Current Medical History

Reason for Physical Therapy: _____
Date of injury or surgical date: _____
Is this a result of a motor vehicle/work accident related? YES NO
If yes, is an attorney or liability insurance involved? YES NO

Past History

Has the patient ever been hospitalized? YES NO
If yes, please describe: _____
_____
Has the patient ever had surgery? YES NO
If yes, please describe: _____
_____

Medications (List all current meds including prescription, over the counter, and herbal supplements)

_____
_____

Allergies (Please list all allergies that the patient has)

_____
_____

Has the patient had or does the patient have any of the following? (Please circle all that apply)

Abnormal blood pressure	Epilepsy/ seizure disorder	Pacemaker
AIDS	Fainting	Polio
Anemia	Fractures	Psychiatric Care
Arthritis	Hearing problems	Respiratory disease
Artificial Joints	Heart problems	Stroke
Asthma	Hepatitis	Thyroid disease
Bleeding disorder	Kidney problems	Tuberculosis
Bowel/Bladder Problems	Liver problems	Ulcers
Cancer	Open wounds	Visual problems
Diabetes	Osteoporosis	

Sports

Does the patient participate in sports? YES NO
If yes, what sport(s), and how often? _____
_____