FIVE STAR
SPORTS REHAB & PHYSICAL THERAPY
A TEAMWORKS Company

PATIENT INFORMATION			
Date:			
Name:			
Phone:	**Cell Phone:**	**Work Phone:**	
Address:			
City:		**State:**	**ZIP Code:**
Email:			
DOB:	**Gender: M F**	**SSN:**	
Emergency contact:			
Phone:	**Cell Phone:**	**Relationship:**	

GENERAL INFORMATION		
Description of injury:		
Date of injury:	**Surgery Date:**	**Pain on a 1-10 scale:**
Primary care physician:		
Address:		
Phone:	**Fax:**	**Date of last visit:**
Referring physician:		
Address:		
Phone:	**Fax:**	**Date of last visit:**
Have you been treated elsewhere for this? Y N		
If yes, where and for how long?		
Have you had physical therapy in the last 12 months? Y N		
If yes, where and for how long?		

INSURANCE INFORMATION			
Medical Insurance:		**Policy/ID#:**	
Subscriber's name:	**Relationship:**	**Employer:**	**DOB:**
Is this the result of a motor vehicle accident? Y N if yes, complete the following			
Motor Vehicle Insurance:		**Date of injury:**	
Contact name:	**Phone:**	**Claim number:**	
Is this the result of a work related accident? Y N if yes, complete the following			
Worker's Comp Insurance:		**Date of Injury:**	
Contact/Adjustor:	**Phone:**	**Claim number:**	

Five Star Sports Rehab and Physical Therapy

30 GREAT RD STE 105 ACTON, MA 01720

P: 978-252-2800 F:978-219-6200

CONSENT TO TREAT

By my signature below, I hereby consent and give permission to **Teamworks Physical Therapy, LLC** to administer Physical Therapy evaluation and treatment.

Initials _____

AUTHORIZATION FOR MEDICAL INFORMATION RELEASE

I give consent for **Teamworks Physical Therapy, LLC** to seek payment from insurers and/or third parties for treatment and services rendered. I authorize **Teamworks Physical Therapy, LLC** to disclose or release any medical information to insurers and/or third parties necessary for payment or processing of claims. Furthermore, I authorize my referring healthcare provider to release any office notes, diagnostic reports and/or surgery reports necessary to aid in evaluation and treatment to **Teamworks Physical Therapy, LLC.**

Initials _____

CO-PAYMENTS/CO-INSURANCES/DEDUCTIBLES

I understand that I am responsible for and agree to pay to **Teamworks Physical Therapy, LLC** 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 **$25 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 **Teamworks Physical Therapy, LLC** of these changes, I will be financially responsible for any and all treatment and charges not covered.

Initials _____

SIGNATURES

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

_____

Patient Signature (Parent or Guardian if under 18) Date