Live Free
PHYSICAL THERAPY

Mill Run Plaza
493 Main Street
Suite 2F
Groton, MA 01450

p: 978-449-9772 f: 978-449-9778

PLEASE PRINT CLEARLY AND COMPLETE ALL ITEMS FOR PROPER PROCESSING OF YOUR CLAIM

SEC 1

NAME _____ (FIRST) ___ (MI) _____ (LAST)

ADDRESS _____ (# STREET APT CITY STATE ZIP) DATE OF BIRTH ___ ___ ___

PHONE _____ SSN _____ SEX ☐ M ☐ F

CELLPHONE _____ ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ OTHER

EMAIL ADDRESS _____

EMPLOYER _____ (NAME CITY STATE PHONE #)

EMERGENCY CONTACT _____ PHONE _____

STUDENT ☐ Y ☐ N SCHOOL _____

SEC 2 **REASON FOR VISIT**

WHAT IS YOUR MAJOR COMPLAINT? _____

DATE PAIN OR PROBLEM STARTED? _____ (DATE)

HAVE YOU RECEIVED ANY OTHER MEDICAL TREATMENT? ☐ YES ☐ NO IF YES, WHERE?

_____ (CLINIC/HOSPITAL ADDRESS TREATING M.D.)

REFERRING MD FOR PHYSICAL THERAPY & TEL # _____

SEC 3 **HOW DID YOU HEAR ABOUT US?**

☐ MD REFERRED _____ (PHYSICAN'S NAME) ☐ MD REFERRAL LIST ☐ FORMER PATIENT _____ (PATIENT NAME)

☐ YELLOW PAGES ☐ INSURANCE PROVIDER WEBSITE ☐ ATTORNEY

☐ GYM ☐ LIVE FREE PHYSICAL THERAPY WEBSITE ☐ ROAD SIGN

☐ INTERNET SEARCH ENGINE ☐ OTHER _____

SEC 4 **HEALTH INSURANCE INFORMATION & AFFIDAVIT**

DO YOU HAVE HEALTH INSURANCE COVERAGE? ☐ YES ☐ NO ***(IF NO, PLEASE READ & SIGN BELOW)***

I DECLARE THAT I AM CURRENTLY NOT COVERED BY HEALTH INSURANCE. _____ (SIGNATURE & DATE)

SEC 5

HIPPA NOTICE OF PRIVACY PRACTICES

WE ARE REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF AND PROVIDE INDIVIDUALS WITH A NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO PROTECTED HEALTH INFORMATION.
YOUR SIGNATURE BELOW IS ONLY TO ACKNOWLEDGE THAT YOU HAVE BEEN GIVEN A NOTICE OF OUR PRIVACY PRACTICES.

PATIENT SIGNATURE _____ DATE _____

SEC 6

HEALTH COVERAGE

PRIMARY INSURANCE _____ PCP _____
NAME TEL #

INSURANCE ID # _____ COPAY $.

PRIMARY INSURED'S NAME _____ DATE OF BIRTH _____

ADDRESS IF DIFFERENT FROM YOURS _____

RELATION TO THE INSURED ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

SECONDARY INSURANCE _____ INS ID # _____

SECONDARY INSURED'S NAME _____ DATE OF BIRTH _____

ADDRESS IF DIFFERENT FROM YOURS _____

RELATION TO THE INSURED ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KNOW MY INSURANCE BENEFITS FOR PHYSICAL THERAPY SERVICES. I WILL BE FULLY RESPONSIBLE FOR ANY COPAYS, DEDUCTIBLES OR BALANCE MY INSURANCE COMPANY DOES NOT COVER.

SIGNATURE _____ DATE _____

SEC 7

TYPE OF INJURY

IS YOUR INJURY A RESULT OF ANY OF THE FOLLOWING?

☐ AUTO ACCIDENT ☐ ACCIDENT AT WORK ☐ SLIP/FALL ☐ PEDESTRIAN ☐ OTHER

IF NO, SKIP TO SECTION 11 **IF YES, FILL IN APPLICABLE INFORMATION**

SEC 8

AUTO INSURANCE INFORMATION

IF YOU WERE IN AN AUTO ACCIDENT WHERE WERE YOU SEATED? ☐ DRIVER ☐ PASSENGER

WHEN DID THE ACCIDENT HAPPEN? _____ IN WHAT CITY? _____
DATE

INSURANCE CARRIER _____ PHONE # _____

POLICYHOLDER _____ CLAIM# _____

INS. ADJUSTER _____ EXT # _____

OTHER VEHICLE'S AUTO CARRIER _____

INSURED'S NAME _____

CLAIM # _____ ADJUSTER _____ EXT _____

SEC 9 **WORKER'S COMPENSATION INFORMATION**

NAME OF INSURANCE _____ DATE OF INJURY _____

CLAIM # _____ MANAGER AT WORK _____

W/C ADJUSTER _____

W/C PHONE # _____ EXT _____

SEC 10 **ATTORNEY INFORMATION**

NAME OF ATTORNEY OR FIRM _____

NAME OF ATTY. HANDLING CASE _____

ADDRESS _____ PHONE _____

STREET CITY STATE ZIP

SEC 11 **MISSED APPOINTMENT POLICY**

LIVE FREE PT IS COMMITTED TO YOUR CARE. WE ASK THAT YOU GIVE THE SAME COMMITMENT TO ATTENDING YOUR APPOINTMENTS. IF YOU NEED TO CHANGE OR CANCEL YOUR APPOINTMENT, A 24 HOUR NOTICE IN ADVANCED IS REQUIRED. **FAILURE TO NOTIFY THE CLINIC OF A CHANGE IN APPOINTMENT WITHIN THE 24 HOUR WINDOW, WILL RESULT IN A $30.00 MISSED APPOINTMENT FEE.**

I HAVE READ AND UNDERSTAND THE MISSED APPOINTMENT POLICY _____ PATIENT INITIALS

SEC 12 **AUTHORIZATION TO PAY PROVIDER & ASSIGNMENT OF BENEFITS**

I hereby authorize and direct my insurance carrier to issue the expense benefits allowed and payable to me under the terms of the insurance policy as payment for services rendered to me by Live Free PT.

I also hereby authorize and direct Live Free PT to release any and all information from my medical records related to my condition in order to process claims.

I verify that all the information provided is true and correct. I agree to promptly notify this clinic of any change in this information until my account is paid in full. I understand that my insurance will be billed as a courtesy and that I remain fully financially responsible for all charges that I incur.

Signature of patient _____ **Date** _____