MAINE FELDENKRAIS & PHYSICAL THERAPY
LEARN TO MOVE, MOVE TO LEARN

PATIENT INFORMATION

Name: _____ Date: _____

Address (Local): _____

City: _____ State: _____ Zip: _____

Home Phone (Local):_____ Work Phone: _____ Cell Phone_____

E-mail: _____

Birth date: _____ Sex: ___M ___F Social Security # _____

Height: _____ Weight: _____ BMI: _____

Parent/Guardian Name: _____

In Case of an Emergency, Contact: _____Phone: _____

Who may we thank for referring you? _____

Primary Care Physician: _____ Phone: _____

MEDICAL INFORMATION

For what are you seeking help from a physical therapist? _____

_____

Have you received care for this condition prior to this current care at MFPT? Yes No

How many caregivers have you consulted/been treated by for this current condition prior to coming to MFPT? _____

List any previous injuries, surgeries, PT, and hospitalizations: _____

_____

What is your occupation? _____

List your hobbies and recreational activities: _____

_____

List all current allergies and medications: _____

_____

Current Smoker: Yes◯ No◯ Packs Per Day _____ Years Smoking _____

Previous Smoker: Yes◯ No◯ Years Smoke Free _____ Years Smoked _____

Alcohol: Yes◯ No◯ Occasionally◯ Never◯ N/A◯

Drugs: Yes◯ No◯ Occasionally◯ Never◯ N/A◯

Do you have and/or have you been diagnosed with any of the following (please check if applicable)?

☐ Cancer	☐ High Blood Pressure	☐ Pulmonary/Lung Problems
☐ Cardiac/heart problems	☐ Impaired Circulation	☐ Stroke/TIA
☐ Diabetes	☐ Metal Implant	☐ Thrombophlebitis

MAINE FELDENKRAIS & PHYSICAL THERAPY

PAYMENT INFORMATION

INSURANCE DATA

Patient Name: _____ Date of Birth: _____

Person Responsible for Account/ Insurance Policy Holder: _____

Policy Holder Birth date: _____ Relation to Patient: _____

Address (if different from patient): _____

Policy Holder Employed By: _____ Business Phone: _____

Primary Insurance Company_____

ID or Certificate No: _____

Group No: _____

SecondaryInsuranceCompany_____

ID or Certificate No: _____

Group No: _____ _____

If you're a Medicare beneficiary, have you had any Physical Therapy this year? _____

If so, what clinic? _____

Is your injury due to: (circle one) Other--------Work Accident--------Motor Vehicle Accident

Date of Injury: _____ State in which accident occurred: _____

Work Injury	Auto Accident
Employer: _____	Auto Insurance Name: _____
Injury Claim # _____	Accident Claim #: _____
Tel #: _____	Tel. #: _____
Contact Person: _____	Contact Person: _____

Attorney Name, Address and, phone #: _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to ***Maine Feldenkrais and Physical Therapy*** all insurance benefits, if any, otherwise payable to me for physical therapy services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature: _____ Date: _____

Please complete the other side…

34 Hennessey Ave. • Brunswick, Maine 04011 • 207.725.7578 • Fax 207.725.7549 • www.maine-feldenkrais-pt.com

CONSENT TO TREATMENT

I consent rehabilitations and related services at Maine Feldenkrais and Physical Therapy. In so doing, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of sensitive nature. _____

TREATMENT OF MINORS

I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.

_____

WAIVER AND RELEASE

I hereby release, discharge, and acquit Maine Feldenkrais and Physical Therapy, it's, representatives, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive, or allow emergency, and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician, or urgent care services. _____

AUTHORIZATION OF PAYMENT

I hereby assign all benefits directly to and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the service I receive, I will be financially responsible for payment. _____

NOTICE OF PRIVACY: I acknowledge receipt of Notice of Privacy Practices. _____

Parent/Guardian Signature_____ Witness Signature _____

PAYMENT AGREEMENT

Please read the following carefully. If you have concerns about your fee, or about payment, please feel free to discuss those concerns. *YOUR SIGNATURE INDICATES THAT YOU AGREE TO THE FOLLOWING:*

1. **Insurance Card:** Please present an **insurance identification card** at or before your session. We're happy to file your insurance claim for you.
2. **Co-pays:** Please pay your **co-pay**, by check, charge, or cash at the beginning or end of each session.
3. **Cancellations and No Shows:** Call to **cancel** or **reschedule** an appointment at least 24 hours in advance: **725-7578.** Clients that do not show up or cancel less than 24 hours eliminate the chance for another person to be scheduled at that appointment time. Clients who do not show up or give 24 hours notice will be charged **$35.00** for that session. You must pay for this missed session prior to receiving your next session. This fee is not covered by insurance.

Signature: _____ Date: _____

MEDICAL RECORDS RELEASE

It is customary to communicate with your primary care physician and other professionals involved in your care. Our modes of communication include Fax, US mail, telephone, and personal conversations. Please indicate your consent for us to do so by signing below.

I give my permission for ***Maine Feldenkrais and Physical Therapy*** to release information about my care to my primary care physician, the other listed healthcare professionals, and my insurance carrier(s):

Professionals included with this consent (list by name, phone #):

_____
_____
_____

Signature: _____
Date: _____