

Merrimack Valley Physical Therapy Policies

Thank you for making MVPT your choice for physical therapy. We understand that there are many options for PT and we appreciate your confidence in us. Please let us know if there is anything we can do to make your experience with us more positive. The following are some of the policies we would like you to know about.

Please initial each section acknowledging that you have read and understand the following policies.

If patient is a minor this form must be initialed and signed by Parent/Guardian

Patient Name: _____
(Please Print)

HIPPA Policy:

I understand and have been offered a copy of the Private Practice Policy that provides a complete description of information uses and disclosures. I understand that Merrimack Valley Physical Therapy reserves the right to change their policy and will post a copy of any revisions to the Private Practice Policy.

_____ Please Initial

Patients Rights

Access:

You have the right to view or obtain copies of your health information including all correspondence to your referring physician. MVPT will provide you with a copy of your initial evaluation that includes the plan of care for your treatment. All other information is available upon your request.

_____ Please Initial

No Show/ Cancellation Policy:

Merrimack Valley Physical Therapy reserves the right to charge a \$30 fee for no shows and cancellations made with less than a 24 hour notice. The 24 hour notification provides our front desk personnel the time necessary to reschedule your therapist with another patient who may be on a waiting list.

Our front desk personnel are committed to assisting you with the scheduling of your therapy and will make every effort to accommodate your schedule to ensure you receive the desired rehabilitation outcomes in a timely manner.

I understand this policy and further understand that any no show/ cancellation charges are not a covered insurance benefit.

_____ Please Initial

Payments/ Billing Office:

Statements are mailed out monthly to patients. If you find at any time you have questions or are having difficulty with payment of your bill please contact our Billing Office in Bedford at 626-4205.

_____ Please Initial

Assignment of Benefits:

I authorize payment otherwise payable to me go directly to Merrimack Valley Physical Therapy for all services rendered to include all insurance carriers and third party liabilities. I understand that I am ultimately responsible for all charges not covered by my insurance.

Signature: _____ Date: _____

(Name of responsible party if minor) _____

Merrimack Valley Physical Therapy Medical History Intake Form

Patient Name: _____ **Date:** _____

Please answer the following questions to the best of your knowledge. This information is intended to help us provide you with our highest level of care by better understanding you.

Do you currently, or have you in the past had any of the following medical conditions?

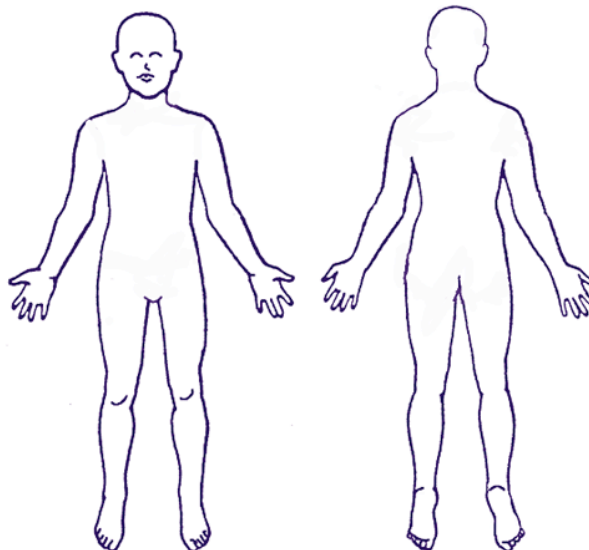
Please check all that apply.

Yes	No		Yes	No	
___	___	High Blood Pressure	___	___	HIV/AIDS
___	___	Heart Disease	___	___	Ulcers
___	___	Congenital Heart Disease	___	___	Pneumonia
___	___	Heart Murmur	___	___	Arthritis
___	___	Rheumatic Fever	___	___	Stroke
___	___	Anemia	___	___	Seizures
___	___	Diabetes	___	___	Kidney Disease
___	___	Tuberculosis	___	___	Pulmonary Disease
___	___	Hepatitis	___	___	Hearing Problems
___	___	Thyroid Disease	___	___	Vision Problems
___	___	Asthma	___	___	Blood Transfusions
___	___	Bleeding Disorders	___	___	Depression
___	___	Cancer	___	___	Pregnancy
___	___	Sleep Disturbances	___	___	Memory Loss
___	___	Anxiety	___	___	Smoking
___	___	Surgeries	___	___	Allergies
___	___	Dizziness	___	___	History of Falls

If you checked **yes** to any of the above, please explain below:

Please draw in your symptoms on the diagram below:

Indicate: Pain With /// Numbness With ooo Tingling With xxx



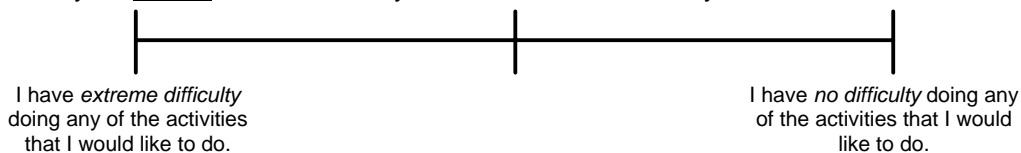
__ I have reviewed the above medical history and it remains unchanged. (signature) _____
date

OPTIMAL INSTRUMENT

Difficulty–Baseline

Instructions: Please circle the level of difficulty you have for each activity today.	Able to do without any difficulty	Able to do with little difficulty	Able to do with moderate difficulty	Able to do with much difficulty	Unable to do	Not applicable
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving–lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Walking–short distance	1	2	3	4	5	9
10. Walking–long distance	1	2	3	4	5	9
11. Walking–outdoors	1	2	3	4	5	9
12. Climbing stairs	1	2	3	4	5	9
13. Hopping	1	2	3	4	5	9
14. Jumping	1	2	3	4	5	9
15. Running	1	2	3	4	5	9
16. Pushing	1	2	3	4	5	9
17. Pulling	1	2	3	4	5	9
18. Reaching	1	2	3	4	5	9
19. Grasping	1	2	3	4	5	9
20. Lifting	1	2	3	4	5	9
21. Carrying	1	2	3	4	5	9

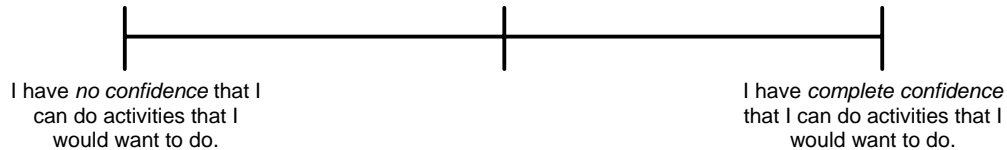
22. Thinking about all of the activities you would like to do, please mark an “X” at the point on the line that best describes your overall level of difficulty with these activities today.



Confidence–Baseline

Instructions: Please circle the level of confidence you have for doing each activity today.	Fully confident in my ability to perform	Very confident	Moderate confidence	Some confidence	Not confident in my ability to perform	Not applicable
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving–lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Walking–short distance	1	2	3	4	5	9
10. Walking–long distance	1	2	3	4	5	9
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15. Running	1	2	3	4	5	9
16. Pushing	1	2	3	4	5	9
17. Pulling	1	2	3	4	5	9
18. Reaching	1	2	3	4	5	9
19. Grasping	1	2	3	4	5	9
20. Lifting	1	2	3	4	5	9
21. Carrying	1	2	3	4	5	9

22. Thinking about all the activities you like to do, please mark an “X” at the point on the line that best describes your overall level of confidence in performing these activities today:



...Your Rehabilitation, Wellness & Injury Prevention Specialists

MVPT PATIENT QUESTIONNAIRE

Patient Name: _____

Date _____

Referring MD _____

Please take a moment to answer the following questions, your assistance is greatly appreciated!

Location of today's appointment: Bedford Londonderry Manchester Nashua

Have you previously been a patient of ours? Yes No

Have you received physical therapy from other providers? Yes No

How did you hear about Merrimack Valley Physical Therapy? (please indicate all that apply)

- Friend or Neighbor If one of our past patients, who can we thank? _____
- Yellow Page Ad
- Newspaper Ad Which paper? _____
- Physician recommendation
- MVPT website
- Insurance network approved
- Other

Have you viewed our Yellow Page Advertisement? Yes No
Suggestions or Comments...

Have you visited our website? (www.mvptandwellness.com) Yes No
Suggestions or Comments...

What is your primary reason for choosing Merrimack Valley Physical Therapy?

Thank you again for your assistance, please let us know if there is any way we can better serve your needs.
David N. Robator, P.T., Stephen W. Ellis, P.T., and Associates