Bolduc Physical / Aquatic Therapy & Sports Medicine
11135 S Jog Road Suite 1
Boynton Beach, FL 33437

Date: _____

Name: _____ M ____ F ____

Date of Birth: _____ Marital Status: _____

Local Address: _____

City, State, Zip: _____

Local Phone: _____ Cell: _____
Emergency Contact: _____ Phone #: _____
GO GREEN! Best Email Address For Billing Statements: _____

YES / NO (Circle one) - Newsletters To Be Emailed

How did you hear about us? □ HSS □ Doctor □ Family □ Friend □ Other
Is this related to an accident? Yes / No
If so: AUTO___ WORK __ Date of incident: _____
Is an attorney handling your claim? Yes / No
Attorney Name / Phone: _____
Please note if this is related to an accident, the front desk needs to be notified prior to you being seen!

ARE YOU CURRENTLY RECEIVING HOME HEALTH? YES / NO PLEASE INITIAL HERE _____
(MEDICARE PATIENTS PLEASE NOTE: MEDICARE WILL NOT PAY FOR OUTPATIENT THERAPY IF YOU ARE RECEIVING HOME HEALTH CURRENTLY. IF YOU HAVE RECEIVED HOME HEALTH WITHIN THE LAST MONTH, PLEASE TELL THE FRONT OFFICE BEFORE BEING SEEN!)

Consent for Evaluation and Treatment
I consent and authorize Bolduc Physical Therapy & Sports Medicine to perform a history, physical examination and treatment with any other routine diagnostic procedures necessary for my care. I have answered all the above questions to the best of my knowledge.
PLEASE INITIAL HERE _____

Medical History
Has a doctor ever told you that you suffer from any of the following problems?

	Yes	No
Heart Attack		
Angina Pectoris		
Stroke		
High Blood Pressure		
Diabetes		
Cancer		
Pacemaker		
Metal Implants		
Allergies		

Medical History Verified by (Therapist): _____
Please list any surgeries or hospitalizations: _____

I have reviewed/received a copy of Bolduc Physical therapy & Sports Medicine's Notice of Privacy practices.
Patient Signature: _____

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COMMERCIAL MEDICAL INSURANCE / MOTOR VEHICLE ACCIDENT ISURANCE
Most commercial insurance will cover at least a percentage of services (usually 80%, however, this varies with policies). Deductibles MUST be met as they are your responsibility. We do NOT accept for assignment for commercial and/or PIP insurance unless we are in network as a provider for your insurance company. We will verify your benefits before your first appointment, but this DOES NOT guarantee payment. You are responsible for whatever your insurance does not cover. Some policies require a copayment as opposed to a coinsurance. Copayments are collected when you are checked in at each visit. We will bill your insurance as a courtesy. ***You and your insurance company have a contract; it is ultimately your responsibility to determine limits, exclusions, deductibles, etc.***

MEDICARE INSURANCE
We will accept assignment for Medicare insurance ,and we will file for you. Medicare pays 80% of the allowed charges. If you do not have a supplemental insurance policy, we must collect the 20% from you directly. We will bill you for the amount not covered by Medicare, or you may choose to pay after each visit. If you have a supplemental insurance, we will file that for you as well. If benefits are paid to you in error, it is your responsibility to pay the provider. **Note:** Each year, Medicare patients have a deductible. This is your responsibility. The deductible varies from year to year. You will be responsible for any treatment provided that exceeds Medicare program standards.

IF YOU ARE RECEIVING ANY IN-HOME CARE THAT IS BEING COVERED BY MEDICARE (THIS INCLUDES PHYSICAL THERAPY, WOUND CARE, NURSING, ETC.), THEY WILL NOT PAY FOR OUTPATIENT PHYSICAL THERAPY IF YOU HAVE NOT BEEN DISCHARGED PRIOR TO STARTING YOUR OUTPATIENT THERAPY.

BENEFIT AUTHORIZATION
I request that payment of authorized Medicare/and or private insurance benefits be made to Bolduc Physical Therapy & Sports Medicine in my behalf for services rendered by Victoria Bolduc, PT, MS or designated representative. I authorize any holder of medical or other information about to be released to the provider/insurance company.
YOU ARE ULTIMATELY RESPONSIBLE FOR THE PAYMENT OF YOUR BILL IN FULL!!!!

BOLDUC PHYSICAL THERAPY IS NOT RESPONSIBLE FOR ANY LOST OR STOLEN ITEMS IN THE CLINIC OR IMMEDIATE SURROUNDING AREAS. PLEASE MAKE SURE TO LEAVE ANYTHING OF VALUE AT HOME OR KEEP CLOSE TO YOUR PERSON. DO NOT ASK THE THERAPIST OR ANY OTHER STAFF MEMBER TO MOVE YOUR BELONGINGS OR HOLD THEM FOR YOU. BOLDUC WILL NOT PAY FOR ANYTHING THAT IS LOST OR THAT ARE STOLEN.

I have read and will comply with above policies that apply to me, and the services that I will be receiving. I understand that my full bill is my sole responsibility and that my account may be turned over to a collection agency or lawyer for collection and I will be responsible for all lawyer fees/ collection fees as well, if payment is not received and I do not make special payment arrangements with the practice administrator.

AUTHORIZATION TO RELEASE MEDICAL RECORDS TO BOLDUC PHYSICAL THERAPY
I give Bolduc Physical my permission to obtain any records that pertain to my treatment. This includes, but not limited to MRIs and operative reports.

Patient Signature _____

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Current Medications List
Please include all prescription, supplements, and over the counter

Patient Name: _____
IF NO MEDICATION PLEASE INITAL HERE _____

Name	**Reason**	**Dose / Frequency**

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING __0__ **+** _____ **+** _____ **+** _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

PATIENT NAME: _____ DATE: _____

ELDER ABUSE SUSPICION INDEX (EASI)

EASI questions: questions 1–5 asked of patient; question 6 answered by doctor.
Within the last 12 months:

1	Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?	Yes	No	Did not answer
2	Has anyone prevented you from getting food, clothes, medication, glasses, hearing aides or medical care, or from being with people you wanted to be with?	Yes	No	Did not answer
3	Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	Yes	No	Did not answer
4	Has anyone tried to force you to sign papers or to use your money against your will?	Yes	No	Did not answer
5	Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	Yes	No	Did not answer
6	*Doctor*: Elder abuse may be associated with findings such as: poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months?	Yes	No	Not sure

'The EASI was developed to raise a doctor's suspicion about elder abuse to a level at which it might be reasonable to propose a referral for further evaluation...While all six questions should be asked, a response of "yes" on one or more of questions 2 to 6 may establish concern.'

PATIENT NAME: _____ DATE:_____