

**Bolduc Physical / Aquatic Therapy & Sports Medicine**  
**5450 W. Hillsboro Blvd. Suite #9**  
**Coconut Creek, FL 33073**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ M \_\_\_ F \_\_\_

SS#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Local Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Local Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Email Address: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**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

	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:** \_\_\_\_\_

*Bolduc Physical / Aquatic Therapy & Sports Medicine  
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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** \_\_\_\_\_

