

PHYSICAL THERAPY GROUP OF FLORIDA

2430 E. COMMERCIAL BLVD. STE B FORT LAUDERDALE, FL 33308

Patient Information: (PLEASE PRINT)

Patient Name: _____ Parent/Guardian Name _____

Date: _____ Age: _____ Date of Birth: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Other Address: _____ City: _____ State: _____ Zip: _____

Home Phone# : (____) _____ Cell Phone#: (____) _____

Email: _____ Most likely reached at: _____

Emergency Contact Name: _____ Relation: _____

Contact Address and Phone: _____

Primary Doctor: _____

Referring Doctor: _____

Employer Name and Address: _____

Occupation: _____

Health Insurance Information

Primary Carrier Name: _____

Address and Phone: _____

ID #: _____ Group #: _____

Secondary Carrier Name: _____

Address and Phone: _____

ID#: _____ Group#: _____

Drivers License #: _____

PHYSICAL THERAPY GROUP OF FLORIDA MEDICAL HISTORY FORM

Patient Name: _____

Date: _____

Are you presently working? Yes _____ No _____

Last Day Worked: _____

Have you ever had these symptoms before? Yes _____ No _____

When? _____

Check those which apply to your current condition:

- ☐ Work Related Injury
- ☐ Motor Vehicle Accident
- ☐ Injury Recurrence
- ☐ Sports Injury
- ☐ Aggravation of Pre-Existing Injury
- ☐ Lifting Injury
- ☐ Fall
- ☐ Causes Unknown
- ☐ Other: _____

Do you have, or have you had any of the following?

	Yes	No		Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to Heat	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to Cold	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Metal Implants	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Fractures	<input type="checkbox"/>	<input type="checkbox"/>
Are You Pregnant	<input type="checkbox"/>	<input type="checkbox"/>	Skin Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/Vomitting	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Ear Ringing	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Aids/HIV	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>

If you answered yes to any of the above, please explain and give an approximate date of occurrence: _____

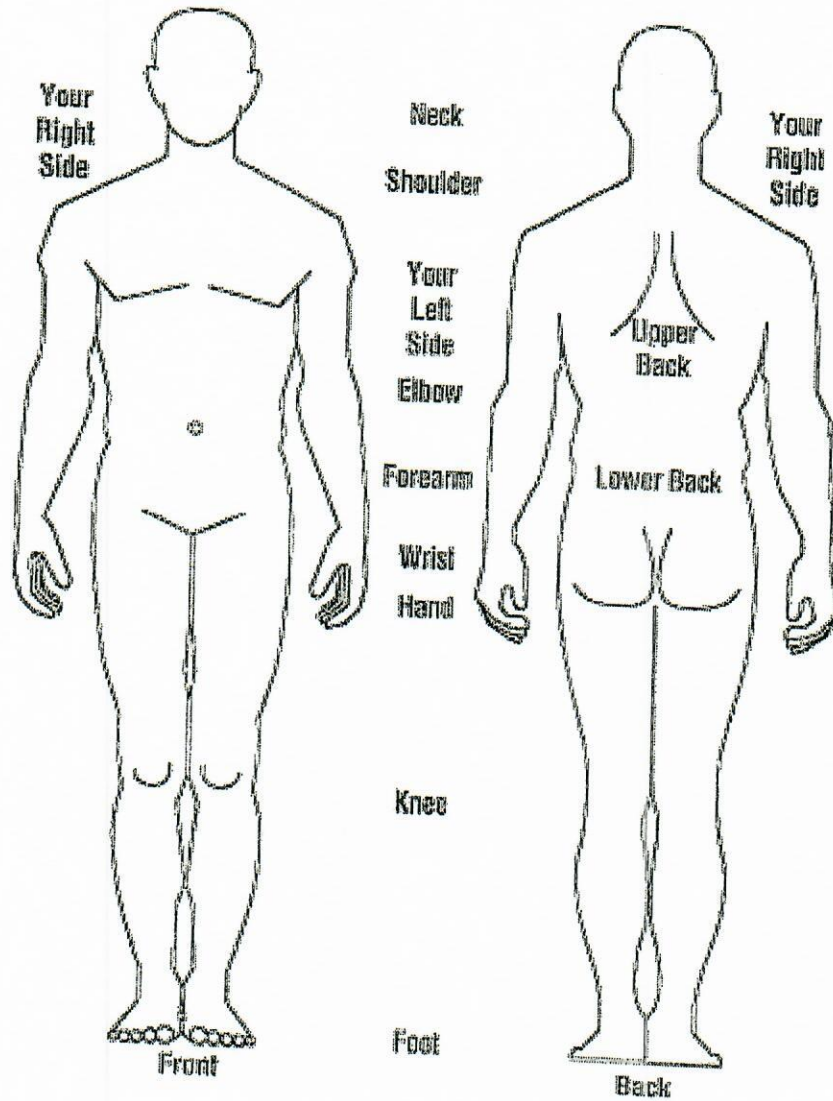
Please circle the test you had performed: X - Rays MRI CT Scan Bone Scan
Other (Explain) _____ None

Is there any other information about your present health that we should know about? _____

Are you presently taking medication? Yes _____ No _____

If yes, What are you taking? _____

Patient Signature _____



Please circle the part/s of your body that are currently in Pain.

Details about your pain:



Authorization/Consent/Financial Policy

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Physical Therapy Group of Florida is hereby authorized to disclose all or any part of the medical record of the patient named in the registration to such insurance companies or agencies as may be concerned with the payment of professional and/or facility costs of the patient named on this registration. The authorization is effective for 2 years from the date of service and may be revoked with written notification.

CONSENT FOR TREATMENT

The patient signing this form consents to any therapy, treatment, or facility services rendered to the patient under the general and special instructions of the therapist assigned to care for me. I also acknowledge that no guarantee or warranty has been made by said therapist of Physical Therapy Group of Florida as to the results of any treatment given or performed.

MEDICARE

Physical Therapy Group of Florida accepts Medicare assignment. This means that we will accept the Medicare approved amount as payment in full for our services. We will bill Medicare and your supplemental insurance company as a courtesy to you. Medicare will pay 80% directly to us and the other 20% must be collected from the patient or from of supplemental insurance company. The Health Care Financing Administration (HCFA) of the United States Government has issued a warning that providers who waive the co-insurance charge or the annual deductible for Medicare are subject to prosecution for fraud. We, therefore, must collect the deductible and the remaining 20%. If your supplemental insurance company does not pay or if your Medicare deductible has not been met, you will receive a statement from us indicating the amount you owe. Dressings and supplies will not be covered by Managed Care Organizations or Medicare; therefore, you will be financially responsible for these items at the time of service.

WORKERS' COMPENSATION

If you are a patient with a valid Workers' Compensation claim, we will bill your employer's insurance carrier for reimbursement on all treatment rendered. If you have reached Maximum Medical Improvement as deemed by the insurance carrier, you will be responsible for co-payment for each visit.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Please read financial policy for our practice.

SCHEDULING AND MISSED APPOINTMENTS

It is the patient's responsibility to make and confirm their appointments. We are unable to guarantee standing appointments but will make every effort to schedule appropriately so that a patient never has an extended wait to see a therapist. If you are unable to attend an appointment we ask as a courtesy that you call 24 hours in advance to let us know. By calling us, you will allow us to make appropriate changes to the schedule. A cancellation fee WILL NOT be charged for missed appointments unlike our competitors. All we ask is a courtesy call to let us know you will not be able to make your appointment.

OUR INSURANCE POLICY

Billing insurance is done as a courtesy to the patient and does not diminish the patient's responsibility for payment full. It is the patient's ultimate responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by the insurance company. Regarding insurance plans where we are a participating provider all co-pays and deductibles are due prior to treatment. Payments sent to the patient must be forwarded to the provider upon receipt. By my signature below, I recognize, understand, and accept that I am ultimately financially responsible for any and all charges for services rendered by including, but not limited to, any services or fees not covered or denied by my insurance company. Additionally, I agree to pay all charges associated with the cost of collection, if my account becomes delinquent, including reasonable attorney's fees, court costs, finance charges, and the legal rate of interest on the account until paid in full.

MEDICAL EMERGENCIES

It is our policy to call 911 in case of medical emergencies

I certify that I have read and understand fully the above information

Signature: _____ Printed Name: _____ Date: _____

PHYSICAL THERAPY GROUP OF FLORIDA

HIPAA COMPLIANCE PRIVACY AND CONFIDENTIALITY

POLICY STATEMENT:

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Although your health record is the physical property of the health care facility, the information in your records belongs to you.

You have the following rights regarding health information we maintain about you:

- You may request that the health care facility NOT use or disclose your health information for a particular related treatment, payment, the facility's general health care operations, and/or to a particular family member, other relative or close friend. Although we will consider your request, please be aware we are not obligated to accept it or to abide by it. For more information about this right, see code 45 of Federal Regulations (C.F.R.) 164.522 (a). The facility may contact you to provide appointment reminders. You have the right to receive confidential communications of your provided health information. As a caveat please understand that communication between staff and patients during therapeutic exercises may be compromised given the physical plant.
- To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing to the Facility Manager/Front Office Coordinator where treatment was rendered. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies and services associated with your request. For more information, see 45 C.F.R. 164.524. Upon written or verbal request of a patient, a release of records form is to be provided to the patient for his or her signature; this form should be provided to the patient as expeditiously as possible; after receipt of the executed records release, a copy of the requested patient records is to be provided with 14 days of receipt of the executed release and in no case, later than 30 days after receipt of the release.
- If you are dissatisfied with the manner which or the location where you are receiving communications from us that are related to your health information, you may request that we provide you with such information by alternative means or at alternative locations. Such request must be made in writing and submitted to the health care facility's Private Officer. We will attempt to accommodate all reasonable requests. For more information about this right, see 24 C.F.R. 164.522 (b).
- You may request that we provide you with a written accounting of all disclosures made by us during the time for which you request. Such requests must be made in writing. Accounting will not apply to the following: disclosures made for reasons of treatment, payment or health care operations; disclosures made to you or your legal representative or any other individual in your care; disclosures to correctional institutions or law enforcement officials; and disclosures for national security purposes. You will not be charged for your first account request, any requests thereafter will be charged at a reasonable fee. For more information, see 164.524. No other disclosures or uses of your medical records will be made other than stated in this document without your written authorization, see 164.520 sub (b) sub (II) (E).
- If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the information. Such requests must be made in writing and must provide a reason to support the amendment. For more information, see 45 C.F.R. 164.526
- You have the right to obtain a paper copy of your Notice of Information Practices upon request.
- You may revoke an authorization to use or disclose health information, except to the health care facility's Privacy Officer.

If you believe that your privacy rights have been violated, you may file a complaint with the health care facility. These complaints must be filed in writing on a form provided by the health care facility. The form can be obtained from the Privacy Officer and returned to the Privacy Officer. You may also file a complaint with the secretary of the Federal Department of Health and Human Services. There will be no retaliation for filing a complaint. There will be no charges in this privacy practice without written notice provided to you setting forth any change.

HIPAA Compliance Officer: Richard D. Serlanni, DPT
954-491-2021 Physical Therapy Group of Florida, LLC

Signature

Date