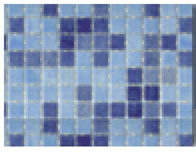
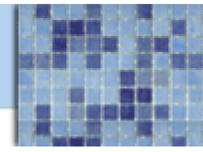
ABSOLUTE Physical Therapy of southwest florida, LLC

PATIENT INFORMATION			EMAIL ADDRESS:_______________
First Name:	Last Name:	Middle Initial:	Date: / /
Address:	City:	State:	Zip:
Birth date: / /	Age:	☐ Male ☐ Female	S.S. #: - -
Home Phone: ( ) -	Alternative Phone (Cell, Pager): ( ) -		Spouse:
Chose Clinic Because/ Referred to Clinic By ☐ Dr.:	☐ Insurance Plan ☐ Family ☐ Friend		
☐ Former Patient ☐ Close to Work/Home ☐ Website ☐ Yellow Pages ☐ Street Sign ☐ Other:			
WORK INFORMATION			
Employer:	Work Phone ( ) -	Ext.	
Occupation:	Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed		
CARE PROVIDER INFORMATION			
Referring Dr:	Referring Dr. Phone: ( ) -		
Regular Dr./PCP	Regular Dr./PCP Phone: ( ) -		
INSURANCE INFORMATION	**(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)**		
Primary Insurance Name:			
Subscriber's Name (If different):	Birth date : / /		
ID. #:	Group/Policy #		
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:			
Name of Secondary Insurance:			
Subscriber's Name:	Birth date : / /		
ID. #:	Group/Policy #		
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:			
AUTO OR WORK INJURY CLAIM	**(PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)**		
Insurance Name: ☐ Auto :	☐ Labor & Industries:		
Adjuster/Claim Manager:	Phone:	Ext.:	
Address:	City	State:	Zip:
Claim #:	Accident Date: / /	Cause:	
ATTORNEY INFORMATION			
Name:	Law Firm:	Phone: ( ) -	
Address	City	State:	Zip:
IN CASE OF EMERGENCY			
Name of Local Friend or Relative (Not Living at Same Address):			
Relationship to Patient:	Home Phone: ( ) -	Work Phone: ( ) -	

I authorize my insurance benefits be paid directly to Absolute Physical Therapy. I understand that I am financially responsible for any balance. I also authorize Absolute Physical Therapy to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE DATE





PAST MEDICAL HISTORY FORM

Patient Name ______________________

BLOOD PRESSURE	YES	NO
Hypertension	☐	☐
Low Blood Pressure	☐	☐
Normal Blood Pressure	☐	☐

HEART DISEASE	YES	NO
Heart Attack	☐	☐
Atherosclerotic Disease	☐	☐
Myocardial Infarction	☐	☐
Rheumatic Heart Disease	☐	☐
Heart Murmur	☐	☐
Do you have a pacemaker	☐	☐

MUSCLE CONDITION	YES	NO
Carpal Tunnel R/L	☐	☐
Tennis Elbow R/L	☐	☐
Back/Neck Problems	☐	☐
Limited Limb Movement	☐	☐

LUNGS	YES	NO
Asthma	☐	☐
Emphysema	☐	☐
Shortness of Breath	☐	☐

JOINT CONDITIONS	YES	NO
Upper Extremity	☐	☐
Dislocation	☐	☐
Lower Extremity Dislocation	☐	☐

OTHER CONDITIONS	YES	NO
Muscular Dystrophy	☐	☐
Rheumatoid Arthritis	☐	☐
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Gout	☐	☐
Fibromyalgia	☐	☐
Diabetes	☐	☐
Hearing Loss	☐	☐
Poor Eyesight	☐	☐
Fainting	☐	☐
Polio	☐	☐

Other: ______________________

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
☐ None	☐ Sitting	☐ Low	☐ Smoking	Packs a Day ____
☐ 1-2 x Week	☐ Standing	☐ Medium	☐ Alcohol	Drinks a Week ____
☐ 3-4 x Week	☐ Light Labor	☐ High	☐ Coffee/Soda	Cups a Week ____
☐ 5+ x Week	☐ Heavy Labor			

What types of exercise do you perform? : ______________________

What things cause stress in your life? :

Are you taking any seizure medication? ☐ YES ☐ NO If yes list name: ______________________

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?

☐ YES ☐ NO If yes list name: ______________________

List all medications you are currently taking: ______________________

List all surgeries in the past two years (Including dates): ______________________

Are you pregnant? ☐ YES ☐ NO What week?: __________

Have you had any injuries related to work? ☐ YES ☐ NO If yes list body part and date.: ______________________

Have you had any Auto Accidents ☐ YES ☐ NO If yes list body part and date.: ______________________

Have you had Physical Therapy this calendar year? ☐ YES ☐ NO Where:

______________________ Signature of Patient, Parent, Guardian, Personal Representative

______________________ Date

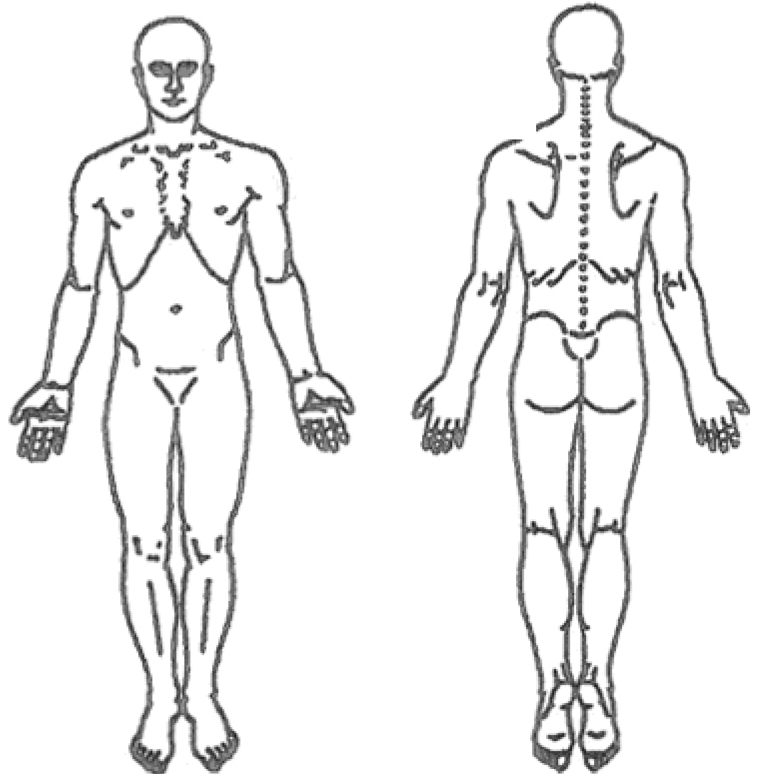
Pain and Symptom Status Report

Name: ______________________________ Date: ______________

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing

Ache	Burning	Numbness
MMM	— — —	O O O O
M	— —	O O O

Pins and Needles	Stabbing	Other
▫ ▫ ▫ ▫ ▫ ▫ ▫ ▫ ▫	/ / / / / / /	x x x x
▫ ▫ ▫ ▫ ▫ ▫ ▫ ▫	/ / / /	x x x



Chief Complaint and Visual Analog Scale

My Chief Complaint is: ______________________________

Date First Symptom of your problem occurred on. ______________

2nd Complaint ______________________________

3rd Complaint: ______________________________

Please circle on the scale below to indicate your CURRENT level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets.

Please circle on the scale below to indicate your AVERAGE level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets.

Please circle on the scale below to indicate your WORST level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets.

Additional Comments ______________________________

Payment Policy

We are happy to further extend your services by filing your primary and/or secondary insurance plan for you. Please select from the following payment choices:

According to ______________________________(insurance carrier) you have satisfied $________________ of your $________________yearly deductible. The blance of $_____________ is payable at the time of service.

Co-payment: $__________________per visit or _______________% per visit.

Worker's compensation: We will bill your worker's compensation carrier for all charges. Please note that you will be financially responsible for all charges if your carrier denies coverage.

Self-pay: Balance paid in full at time of service.

H.M.O. Waiver: I am attesting that I have not enrolled in or dis-enrolled from Medicare **H.M.O. in the past 90 (ninety) days**: I understand that if it should later be discovered that I did enroll/dis-enroll and this prevents Medicare from making payment I will be responsible for the full payment of all charges.

There may be a difference between an insurance company's usual and customary charges and our fee schedule. The patient would be responsible for any difference not paid by insurance.

If you cannot keep your appointment for any reason please call 24 hours prior to your appointment. If you do not show or if you cancel 2 times without 24 hours notice, a fee of $20.00 will be applied. This charge will not be billed nor paid by your insurance. All future appointments will be cancelled until this fee is paid.

Please be advised that we are not a credit guarantor. Therefore, failure to maintain these arrangements may result in the placement of your account with an agency or attorney for collections.

You will remain financially responsible for services rendered, regardless of the patient option selected above. In the event your account becomes delinquent and is there fore in default of payment, the patient, legal guardian, or admitting parent will be responsible for the principle amount owed and all reasonable costs associated with the recovery of this debt.

Thank you for allowing us the opportunity to serve you. If you have any questions about the above information or any uncertainty regarding your insurance overage, please ask for assistance.

Kindly sign and date this form to indicate that you understand and agree to the terms of this payment policy.

____

Signature   Date

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

Absolute Physical Therapy – Legal Duty

Absolute Physical Therapy is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

Uses and Disclosures of Health Information

Absolute Physical Therapy uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care that we provide. For example: **Absolute Physical Therapy** may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Absolute Physical Therapy may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, **Absolute Physical Therapy** policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Absolute Physical Therapy may change its policy at any time. When changes are made, a new Notice of Information Practices will be posed in a common area of our clinic. You may also request an updated copy of our Notice of Information Practices at any time.

Patient's Individual Rights

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You may also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment of other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. **Absolute Physical Therapy** will consider such request on a case-by-case basis but the Company is not legally require to accept them.

Concerns and Complaints

If you are concerned that **Absolute Physical Therapy** may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our HIPAA Compliance Office a the address listed below. You may also send a written complain to the US Department of Health and Human Services.

Absolute Physical Therapy
Of S.W. Florida, LLC
9401 Fountain Court D-101
Bonita Springs, FL 34135

Patient Information Consent Form

I have read and fully understand ***Absolute Physical Therapy Notice*** Information Practices. I understand that ***Absolute Physical Therapy*** may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the Company in writing. I also understand that ***Absolute Physical Therapy*** will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in ***Absolute Physical Therapy*** Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the Company in writing at any time.

____
Patient Name

____
Signature

____
Date

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