Professional Physical Therapy and Associates Ltd. Co.

1316 S Ridgewood Ave (U.S. 1), Suite 1• Edgewater, FL 32132 • Tel: (386) 423-0100 • Fax: (386) 428-8631 • www.Proptfl.com

PATIENT INTAKE FORM

Name:____ Date of Birth:___/___/______

Nickname:_________________________________ Social Security #:_______-_______-______

Local Address:____

City:________________________________ State:________________ Zip Code:___________

*(Please check preferred method of contact)

- o Home Phone:________-_______-________
- o Cell Phone:________-_______-________

*(Does cell phone have Text Ability: Yes / No)

*Email Address:____

*(Used for mailing purposes and Home Exercise Programs)

Occupation:____

Place of Employment:____

Ins. Company: Name:_____________________________ Policy #:________________________

Is This Work Related or Due to Auto Accident? Yes / No If Yes, Claim#:__________________

Adjuster or Case Manager Name:___________________ Date of Injury; ____/____/________

Emergency Contact: Name____________________________ Number_____________________

If Applicable:

Out of State Address: ____

City: _____________________________ State: _________ Zip Code:________________

PATIENT/GUARDIAN SIGNATURE________________________________DATE:____________

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CONFIDENTIAL MEDICAL HISTORY FORM

NAME:____

Injury or Reason for Visit:____

When did Symptoms begin? _____________ Diagnostic Testing Done? ____________________

Have you received Therapy for this in past? Yes / No Any Therapy This Year? Yes / No

Surgery? Yes / No Date of Surgery? ____/_____/______

Hospitalization? Yes / No Date of Hospitalization? From:___/___/____ To: ___/___/____

Are you having Pain? Yes / No On a scale of 1 – 10 *(10 being emergency room pain)

What is your pain level at its worst? _________ At Current? _________ At its Best? __________

Are you receiving any Home Health Care? Yes / No Date of Discharge:_____/_____/______

FALLS: Have you fallen? Yes / No If Yes, Date of Last Fall: _____/_____/_______

Surgical History: ____

Medication List: or *(See Attached):____

____

*(When was list of medication(s) last revised by Primary Care Physician?) Date: ______/_____/_______

Do you Smoke? Yes / No Alcohol Consumption? _______/week Are you Pregnant? Yes / No

*Please check medical conditions you currently have or had in the past

	Asthma, Bronchitis, Emphysema		Arthritis, Swollen Joints		Shortness of Breath, Chest Pain
	Osteoporosis		Coronary Heart Disease		Varicose Veins
	Pace Maker		Gout		High Blood Pressure
	Sleeping Difficulties		Heart Attack, Surgery		Emotional, Psychological Problems
	Stroke/TIA		Bowel or Bladder Problems		Epilepsy/Seizures
	Severe/Frequent Headaches		Thyroid Trouble/Goiter		Vision/Hearing Difficulties
	Anemia		Dizziness or Faintness		Infectious Disease
	Cancer or Chemo/Radiation		Diabetes		

PATIENT/GUARDIAN SIGNATURE:________________________________**DATE:**_____________

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PAYMENT POLICY & CONSENT TO TREAT

PAYMENT POLICY: Our staff will verify your insurance as a courtesy and will notify you the information they receive. Insurances always state it is not a guarantee of payment. As the patient, it is your responsibility to be familiar with your particular insurance policy and its obligations. This includes your obligations to see a participating provider, know your coverage and its limitations, and be prepared to pay any out-of-pocket expenses at the time of your visit. Please refer to our website www.proptfl.com for further explanation.

Health care regulations require us to collect all copayments, coinsurances, deductibles and balances for non-covered service fees. Failure on our part to collect from the patient their financial responsibility can be construed as fraud.

If for some reason you find it necessary to cancel a visit, please call us within 24 hours of your appointment to reschedule, as there is a time on the schedule reserved specifically for you. Cancellations are sometimes unavoidable, however, in order to enforce this policy you will be charged $40 if you cancel less than 24 hours prior or you do not show up to your scheduled appointment. We are obligated to report all no-show and cancellations to your doctor and the involved insurance companies. Worker's compensation patients must take extra precautions in attending physical therapy as treatment can be disrupted for non-compliance.

ACKNOWLEDGEMENT

I have read the above, and understand my responsibilities regarding my insurance coverage and payment policy. I understand that I am responsible for any charges that are not covered by my insurance carrier. I understand that I am responsible to notify the office of any changes in insurance that may occur. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred.

SIGNATURE: ____ DATE: ______________

CONSENT TO TREAT:

I, ________________________, hereby agree and give my consent to receive medical treatment for my physical condition. I authorize release of any medical information needed to process my claim. I authorize release of payment to **PROFESSIONAL PHYSICAL THERAPY AND ASSOCIATES LTD CO,** regardless of participation in or out of network. I acknowledge that I have received, read and understand the **NOTICE OF PRIVACY PRACTICES.**

SIGNATURE: ____ DATE: ______________

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PRIVACY POLICIES AND PRACTICES

Revised February 27, 2018

We provide physical therapy and related services to our individual, corporate and association clients (“Clients”).

1. **Information we collect:**

We collect nonpublic personal and medical information about the Clients, in certain cases their family members, and from our individual Clients (collectively “Participants”) from following sources:

- Information we receive from Clients and Participants on intake forms, Photographs or Video in connection with providing services to Clients and Participants.
- Information we receive as a result of processing and verifying the information provided to us about Clients and Participants.
- Information we receive from affiliates, insurers, other intermediaries, third party providers and others regarding our Clients and Participants.
- Information we receive from consumer reporting agencies.
- Information available from external sources (such as publicly available records).
- Photographs and or Video may be used for identification purposes, as well as exercise information.

2. **Information we may disclose to third parties:**

We do not disclose any nonpublic personal information about our Clients, former Clients, Participants of former Participants to any third parties except to process payment for treatment or inform referring physician or other members in the healthcare team for the Client’s benefit. We may share this information outside the company in order to process or complete the transaction for which the information was provided or as otherwise authorized by our Clients or Participants. The law permits us to share this information with our affiliates.

3. **Our practices regarding information confidentiality and security:**

We restrict access to nonpublic personal information about Clients and Participants to those who need to know that information in order to provide products or services to our Clients and Participants. We have in place physical, electronic and procedural safeguards in order to guard any nonpublic personal information we maintain regarding Client and Participants in full compliance with HIPPA regulation. Any contractors providing service in the confines of this practice is also expected to comply completely with this policy.

Due to the nature of semiprivate (curtained) and gym treatment areas there is limited ability to prevent others from hearing discussion regarding possibly confidential patient information. If privacy is required regarding a subject a Client and or Participant can request a private room when available.

Video surveillance on the premise both interior and exterior is used for notification of the providers of arrival of the Client and Participants for the appointment and for safety and security purposes. In the event of a crime the video may be subpoenaed by law enforcement.

Signature: ______________________________ **Date:** ____________