SoFLo PHYSICAL THERAPY

PATIENT INFORMATION

First Name: _____ **Last Name**: _____

Gender: **M: ___ F: ___ Date of Birth:** _____ /_____ /_____ SS#:_____ -_____ -_____

Mailing Address: _____ **City:** _____ State**:** _____

Zip Code: _____ **County:** _____ **Cell #:** _____-_____-_____

Home #: _____- _____-_____ **Other #:** _____- _____- _____

Email: _____ **Marital Status:** Single_____ Married _____

Employer's Name: _____ **Occupation:** _____

Injury Date: _____ **Surgery Date:** _____ **Injury: Work or Auto related?** _____

If auto related, please enter date of accident and auto insurance: _____

Emergency Contact: _____ **Relationship:** _____ **Phone #:** _____ - _____ - _____

Medicare Patients, have you in the past 12 Months received **home therapy? Y / N_**

Referring Physician Name or **Primary Care Physician**: _____

Phone #: _____ -_____ Fax #: _____ -_____

Who can we thank for this referral? Check one: ☐**Doctor** ☐**Facebook** ☐**Friend** ☐**Instagram**

Please bring prescription from your physician and a copy of your insurance card & Picture ID or any other medical information. If your injury is work or auto related please provide us with your claim #, claim adjuster information, and date of accident. Please wear appropriate clothing based on the location of your injury. For example, shorts for a lower extremity (hip, knee or ankle), loose or sleeveless shirt for a shoulder injury.

INSURANCE INFORMATION

Name of Insurance: _____ Policy #: _____

Claims Address: _____ City: _____ State: _____ Zip Code: _____

Policy Holder: _____ SS#: _____-_____-_____ **Date of Birth**: _____

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

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NAME: _____ **DOB:** _____

Past Medical History: Have you ever been told you have any of the following?

Cancer	Yes	No	Ulcers	Yes	No
Heart problems	Yes	No	Infectious diseases	Yes	No
High Blood Pressure	Yes	No	Lung problems	Yes	No
Angina/Chest Pain	Yes	No	Hepatitis	Yes	No
Asthma	Yes	No	Anemia	Yes	No
Diabetes	Yes	No	Allergies	Yes	No
Osteoporosis	Yes	No	Fibromyalgia	Yes	No
Thyroid problems	Yes	No	Kidney disease	Yes	No
Rheumatoid arthritis	Yes	No	Stroke	Yes	No
Osteoarthritis	Yes	No	Seizures/Epilepsy	Yes	No
Depression	Yes	No	Other _____		

Currently, are you experiencing any of the following? (Circle all that apply)

Fever/chills/sweats	Poor balance (falls)	Unexplained weight loss	
Numbness/tingling	Changes in appetite	Difficulty swallowing	Pelvic pain
Depression	Shortness of breath	Changes in bowel or bladder function	
Dizziness	Nausea/vomiting	Night pain	Headaches

How have you been sleeping at night? Fine Disturbed only with medication

What is your smoking status? __never__past ___current; frequency _____

Current History

What date (approximately) did your present symptoms start? _____

Surgery date or injury date? _____

How? (gradually, suddenly, injury) _____

How have your symptoms changed? getting better about the same getting worse

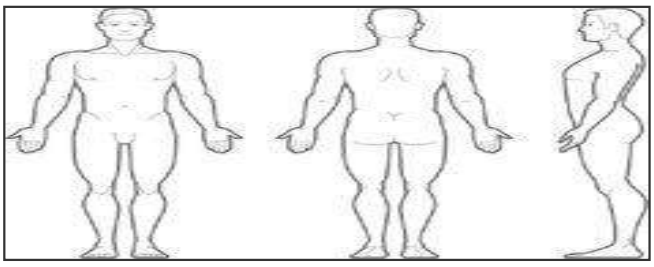
What makes your symptoms better? _____

What makes your symptoms worse? _____

Have you had an x-ray, MRI, or other testing for this problem? No / Yes (specify) _____

What treatments have you received for this problem so far? _____

Body Chart:
Mark the areas where you feel your symptoms.



On the scale below, circle the number which best represents the average level of pain you have experienced:

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst pain imaginable

Circle the number below which best represents your overall average level of function:

0 1 2 3 4 5 6 7 8 9 10

Cannot do anything — Able to do everything

Aggravating Factors: Identify up to 3 important activities that you are unable to do or have difficulty with because of your problem.

1) _____
2) _____
3) _____

During the past 3 months, have you seen any medical professional (doctor, chiropractor, PT, osteopath, etc.)? Yes / No If yes, please describe the reason. _____

_____

Have you had any falls in the past year? __Yes __NO

List any other injuries you have had that required medical attention. _____

_____

What are your personal goals for therapy currently? _____

_____

CONSENT: The information I have provided above is accurate and complete.

_____ _____
(Signature) (Date)

Thank you for your patience and valuable time!

DR NOTES

_____

_____

_____

_____

_____

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We here at SoFlo PT are committed to providing you with the best in Therapy Care. In order to do this without compromising our patients; this policy has been implemented for each patient. If you have medical insurance, we are anxious to assist you in receiving your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

Payment for services is due at the time services are rendered unless other acceptable and agreed upon arrangements have been approved in advance by our staff. We accept cash, checks, Visa, MasterCard and American Express. We will be accommodating to you in the process of seeking reimbursement form your insurance carrier. In special instances we may accept assignment of insurance benefits.

Deductibles and Co-payments must be made at each visit. It is our policy to collect a percentage of each visit or the entire fee until a deductible has been reached.

Please be further advised that Returned checks and balances older than 30 days from your treatment discharge may be subject to additional collection and legal fees, as well as, interest charges of 1.6% per month.

If you participate with our in-network groups such as **MEDICARE, BCBS, AMBETTER, UHC, AETNA, TRICARE, AVMED**, **Auto insurances**. We will bill your insurance company and accept assignment of benefits. **You will be responsible for any co-pays or deductibles at each visit.** We will verify your coverage and determine your out of pocket cost before treatment or after your first visit. We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize, however, that:

1. **Your insurance is a contract between you, your employer and the insurance company.**
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier.
3. Not all services and diagnosis codes are a covered benefit in all insurance contracts.
4. We will not COMPRISE patient care based on an insurance companies "FEE SCHEDULE".
5. **Verification of your insurance benefits is not a guarantee that payment will be made.**

In cases involving Auto Claims and Worker's Compensation, we will ONLY accept payment directly from the patient or from their insurance company and we do not work with ANY LOPs. If a patient has instructed their insurance company to send payment to their attorney, the patient will be billed and held solely responsible and accountable for their bill.

We must emphasize that as a Medical provider, our relationship is with you, not your insurance company. While the filing of an insurance claim is a courtesy that we extend to our patients, all charges are your responsibility from the date the services were rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above policy or any uncertainty regarding your insurance coverage, PLEASE don't hesitate to ask us. **WE ARE HERE TO HELP YOU**!

_____ _____

Patient's Signature / Insured Date

_____ _____

Practice Representative Date

PATIENT MISSED APPOINTMENT POLICY

We here at SoFlo PT, strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well-being and gain of your abilities is something everyone in our clinic takes quite seriously. Because we care so much about you we realize that it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive and to the actions we ask you to do. Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore, we have certain rules that need to be followed to ensure the most optimum results. We expect you to keep all your appointments. We will provide you with a calendar at the front desk for all your appointment times. With the exception of serious emergencies, it is expected that you keep all your appointments. If you need to re-schedule an appointment, we require 24-hour notice. In such a case, please call our office and arrange for a make-up appointment with our Front Desk. However, due to the popularity of our staff we cannot guarantee that we will be able to reschedule you to keep you compliant with your plan of care. **In an instance of cancellation, without 24-hour notice, we reserve the right to charge you a $25.00 fee. In an instance of a no-show you will be charged a $50.00 fee.** In instances of repeated noncompliance with your scheduled visits, we also reserve the right to discontinue care and will inform your physician of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation order: We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

TREATMENT COMMITMENT

SoFlo PT cares very much about each person we treat. We are committing to you, our patient, to deliver Exceptional Care, with Exceptional Results! We request of you, our patient, to deliver a commitment to help us deliver what we promise, by understanding what is required of you. You play a large role in your health by the actions you choose to take. Listed are some of your responsibilities as a patient at SoFlo Pt:

1. Attending, on time, all scheduled appointments.
2. Informing your therapist of your progress, each visit.
3. Compliance with your treatment plan developed by your therapist.
4. Asking questions when you do not understand any instructions given to you by our staff.
5. Notifying your therapist in advance of your next doctor's appointment.

Together, we can accomplish the task set before us, as a team. That's the way healthcare is meant to be.

MVA POLICY (Auto)

For your convenience, we will attempt to bill your automobile insurance if the policy includes personal Injury protection (PIP) coverage. Please note, we cannot bill the other person's auto insurance.
At the point your automobile PIP is exhausted, we will bill your health Insurance or offer a Self-Pay Option. Please provide the front office this information before your visit.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize South Florida Physical Therapy & Sports Rehab, to obtain my Protected Health Information including, but not limited to, History and physical exam, lab reports, progress notes, X-ray reports, substance abuse (including alcohol/drug abuse), Mental Health (including psychotherapy notes), HIV related information (including AIDS related testing). I understand that this authorization will expire 365 days from the date I have signed this form and that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified, except to the extent action has already been taken in reliance upon it. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.

PRIVACY NOTICE

By my signature below, I acknowledge that I have received a copy of this practice's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law and understand my rights as a patient regarding my personal health information.

_____ _____

Patient's Signature/Insured | Date

SoFLo PHYSICAL THERAPY

SCHEDULE, CANCELLATION, & NO SHOW POLICY

- Except for serious emergencies, it is expected that you keep all your appointments.
- If you need to re-schedule an appointment, **we require 24-hour notice.** In such a case, please call our office and arrange for a make-up appointment with our Front Desk.
- In an instance of cancellation, **without 24-hour notice**, we reserve the right to charge you a **$25.00 fee. In an instance of a no-show you will be charged a $50.00 fee.**
- Saturday Appointments: will require verbal confirmation by Thursday or Friday the latest. No show for Saturday appointments will be charged $50.00.
- In instances of repeated noncompliance with your scheduled visits, we also reserve the right to discontinue care and will inform your physician of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

CREDIT CARD AUTHORIZATION FORM

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled. The following information will permit charges for any additional related services such as cancellation fees, no-shows, and patient payment responsibility that you may incur.

Credit Card Information
Card Type: ☐Mastercard ☐VISA ☐Discover ☐American Express ☐Other
_____ Cardholder Name (as shown on card):
_____ _____ Card Number & CVC Code:
_____ Expiration Date (mm/yy):
_____ Cardholder ZIP Code (from credit billing address):

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you. Thank you!

_____ _____

Patient Name **Date**

RELEASE FROM LIABILITY AND EXCULPATORY AGREEMENT

THIS IS A LEGAL BINDING AGREEMENT. READ THIS AGREEMENT CAREFULLY BEFORE SIGNING.

For purposes of this Agreement, "South Florida Physical Therapy and Sports Rehab" means South Florida Physical Therapy and Sports Rehab, including its employees, officers, directors, shareholders and representatives.

I acknowledge that physical training can be strenuous and subject to risk of serious injury. I agree that by participating in personal training sessions with South Florida Physical Therapy and Sports Rehab, whether today or in the future, I am doing so entirely at my own risk.

I hereby acknowledge and agree that my use of any and all physical training services or equipment involves risks of injury to persons. I assume full responsibility for such risks. I hereby agree to voluntarily and unequivocally release and hold South Florida Physical Therapy and Sports Rehab harmless from any and all claims, demands, causes of actions and liabilities arising out of, related to, or connected with any injury, loss or damage, including injury leading to death, whether caused by the active or passive negligence of South Florida Physical Therapy and Sports Rehab or otherwise, which may occur in connection with my participation in any and all personal training sessions with South Florida Physical Therapy and Sports Rehab. I agree to forever give up any claim or demand on account of any injury to my person or property while I am in, upon, or about South Florida Physical Therapy and Sports Rehab facilities, or while receiving personal training sessions from South Florida Physical Therapy and Sports Rehab at any other location, including but not limited to my own residence.

I also hereby acknowledge that South Florida Physical Therapy and Sports Rehab may provide physical therapy services relating to health-related conditions, illnesses, or injuries that may limit my ability to move and perform functional activities. I acknowledge and agree that South Florida Physical Therapy and Sports Rehab is not aware of my particular fitness or physical capabilities or limitations, unless disclosed in detail by the undersigned. Prior to receiving any physical therapy, I agree to disclose in writing all known injuries, ailments and conditions to South Florida Physical Therapy and Sports Rehab. Unless stated in writing, I have not provided such disclosures.

I hereby agree that South Florida Physical Therapy and Sports Rehab shall not be liable for any injury, loss or damage, whether or not I am aware of any existing physical condition or ailment that could be aggravated, or be subject to any claim demand for injury or damage whatsoever, including without limitation, those damages from acts of passive or active negligence of South Florida Physical Therapy and Sports Rehab, in connection with receiving physical therapy from South Florida Physical Therapy and Sports Rehab. I hereby expressly forever release and discharge South Florida Physical Therapy and Sports Rehab from all such claims, demands, injuries, damages, actions or causes of action.

I also covenant and agree that I will not institute, prosecute, or in any way aid in the institution or prosecution of, any demand, claim, or suit against South Florida Physical Therapy and Sports Rehab for any loss, damage, or injury (including death) to my person or property which may occur from any cause whatsoever as a result of my receiving any physical therapy or personal training sessions from South Florida Physical Therapy and Sports Rehab. I know, understand, and agree that I am freely assuming the risk of my personal injury, death, or loss that may result while participating in such activities, including such injuries, death, damage or loss as may be caused by the negligence of the South Florida Physical Therapy and Sports Rehab.

This Agreement applies to and binds my personal representative, heirs, and family.

If any portion of this release from liability shall be deemed by a Court of competent jurisdiction to be invalid, illegal, or unenforceable, such provision shall be fully severable; the remainder of this agreement shall remain in full force and effect and shall not be affected by the invalid, illegal or unenforceable provision.

I have read this agreement in its entirety. By signing this agreement, I am acknowledging that I understand its contents and further represent that this agreement has not been entered under any duress. I am further acknowledging and assuming risk and liabilities, covenanting not to sue South Florida Physical Therapy and Sports Rehab, and waiving claims and rights to make claims in the future.

By signing this release, I acknowledge that I understand its content and that this agreement cannot be modified orally.

<u>WAIVER OF JURY TRIAL:</u> SOUTH FLORIDA PHYSICATHERAPY AND SPORTS REHAB AND THE UNDERSIGNED KNOWINGLY, IRREVOCABLY, VOLUNTARILY, AND INTENTIONALLY WAIVE ANY RIGHT WHICH THE PARTY MAY HAVE TO A TRIAL BY JURY IN RESPECT OF ANY ACTION, PROCEEDING OR COUNTERCLAIM BASED ON THIS AGREEMENT AND ANY AND ALL OTHER MATTERS PERTAINING TO THE AGREEMENT, TOGETHER WITH ANY COURSE OF CONDUCT, COURSE OF DEALING, STATEMENTS (WHETHER VERBAL OR WRITTEN), OR ACTIONS BY ANY PARTY HERETO. THIS PROVISION IS A MATERIAL INDUCEMENT FOR THE PARTIES ENTERING INTO THIS AGREEMENT.

Signed: _____

Printed Name: _____

Date: _____