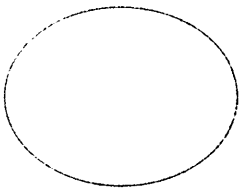


ABSOLUTE REHAB THERAPY
New Patient Registration

PATIENT INFORMATION

Name: _____ Date: _____

Street Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____ Birth Date: _____ Age: _____

Email: _____

Home phone: _____ work: _____ cell: _____

Occupation: _____ Referring physician: _____

Have you had any PT or Home Health this year? If so, when _____

Have you been treated at Absolute Rehab Therapy before? YES NO If yes, when and by whom? _____

How did you first hear about Absolute Rehab Therapy? (Circle one): *Family/Friend Internet Doctor Other:* _____

How would you like to be notified? _____

If a family or friend referred you, please write their name here so we may thank them: _____

Emergency Contact: _____ Relationship: _____

Phone: day _____ evening _____

AUTHORIZATION TO RELEASE INFORMATION AND CONSENT TO TREATMENT

I hereby authorize the release of any information by telephone or in writing, including reports of diagnosis, treatment, prognosis, recommendations, benefits payable, and any other data pertinent to my treatment, by Absolute Rehab Therapy Physical, to my physician(s) as well as any organization responsible for payment of my account. I authorize my insurance company to pay medical benefits directly to Absolute Rehab Therapy in instances where a claim has been filed by Absolute Rehab Therapy on my behalf. I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while I am a patient of Absolute Rehab Therapy. I understand that I play a role in this care and can question or refuse treatment at any time.

_____	_____	_____
Printed name of Patient or Guardian	**Signature of Patient or Guardian**	**Date**

GENERAL POLICIES

- Please notify the front desk if there are any changes to your address, phone number or insurance plan.
- Out of courtesy to your fellow patients, please refrain from using your cell phones in the treatment and gym areas.
- To ensure your safety, please do not use any equipment in the gym that you have not been instructed in and cleared to use by your physical therapist.

I have read, understand, and agree to all the above policies.

SIGNED: _____ **DATE:** _____

3100 S. Federal Hwy, Ste A Delray Beach, FL 33483 Office: 561-241-4411 Fax: 561-241-4211
e-mail: absoluterehabtherapy@gmail.com

CURRENT HISTORY/SYMPTOMS

Name: _____

Describe your current symptoms and/or activity limitations:

_____

Describe when and how your injury occurred:

_____

Have you had any diagnostic tests? □MRI □x-ray □bone scan □_____ If yes, what were the results?

_____

What, if any, treatment have you had for this problem? □ physical therapy □ chiropractic □ acupuncture □ other_____

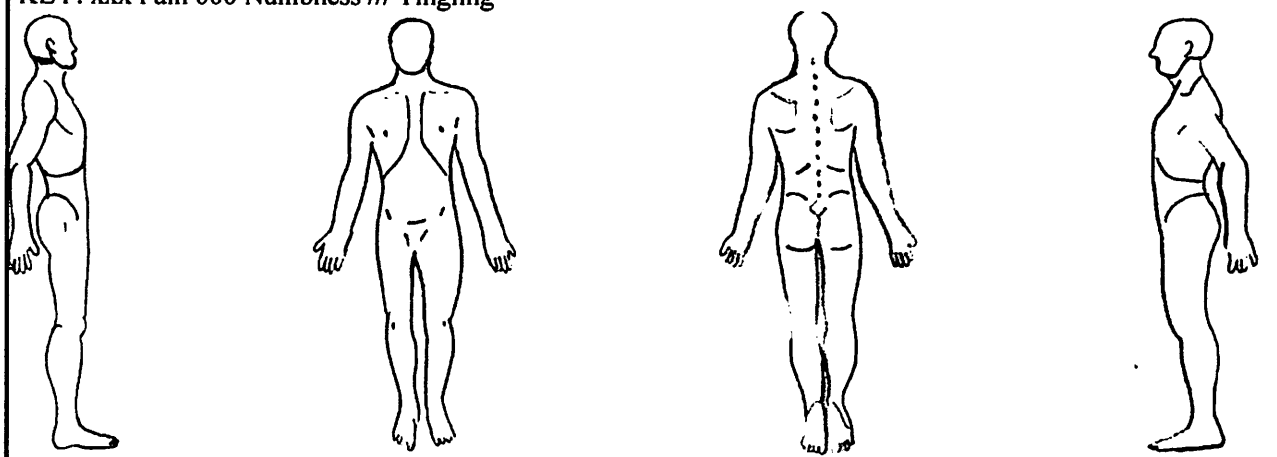
When and how frequently did/do you have this treatment? _____

Did this treatment help? (Please explain) _____

Have you had similar symptoms in the past? _____ If yes, please describe, and list the last date prior to this recent incident or flare that you had these symptoms: _____

Please indicate where your pain is located and what type of pain you feel at the present time. Use the symbols below to describe your pain. Do not indicate areas of pain which are not related to your present injury or condition.

KEY: xxx Pain 000 Numbness /// Tingling



Rate your pain on a visual scale (0-10, 0=no pain, 10=excruciating pain):
Worst it has been _____ Past 2-4 weeks _____ Past 24 hours _____ At this moment: _____

Indicate the nature of your pain/symptoms (check all that apply): □ sharp □ dull □ shooting □ aching □ stabbing □ burning □ stabbing □ deep □ superficial

Are your symptoms worse in the: □ morning □ afternoon □ evening □ inconsistent □ constant

Are your symptoms: □ improving □ worsening □ stable

What actions, activities or positions ***aggravate*** your symptoms/pain? _____
What actions, activities, positions, treatments, or medications ***ease*** your symptoms/pain? _____
Special questions: *Please mark "no" if appropriate. Otherwise, please explain in the lines provided.*
No My pain is constant (24 hours/day, 7 days/week) _____

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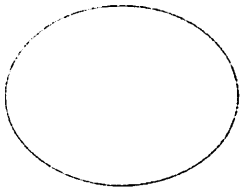

No My pain travels (e.g. from neck to hand or back to foot) _____
No I have a metal implant or surgical hardware in my body _____
No I have a pacemaker or other implanted device in my body _____
No I have weight-bearing restrictions given to me by my doctor _____
No I have osteoporosis or a history of fractures _____
No I have contact allergies to adhesives, latex, rubber, ice, etc. _____
No I have a heart condition and was told not to do physical activity _____

Please list your current medications (prescription and over the counter): _____

Is your injury work related? _____ **Motor vehicle accident?** _____

Does your occupation consist of: ☐ Sitting ☐ Standing ☐ Walking ☐ Lifting ☐ Heavy computer work ☐ Performing on a raked stage ☐ Partnering ☐ Jumping ☐ Dancing in high heels ☐ Kneeling ☐ Squatting ☐ Wearing large costumes/headpieces

☐ Other significant physicality: _____

What are your goals for physical therapy? _____

MEDICAL/INJURY HISTORY

Have you EVER been diagnosed as having any of the following conditions?

☐Yes ☐No Allergies	☐Yes ☐No Circulation Issues	☐Yes ☐No Hearing loss	☐Yes ☐No Parkinson's
☐Yes ☐No Anemia	☐Yes ☐No Diabetes	☐Yes ☐No Heart disorders	☐Yes ☐No Repeated infections
☐Yes ☐No Angina	☐Yes ☐No Digestive issues	☐Yes ☐No HBP	☐Yes ☐No Skin issues
☐Yes ☐No Arthritis	☐Yes ☐No Depression	☐Yes ☐No Infectious diseases	☐Yes ☐No Stroke
☐Yes ☐No Asthma	☐Yes ☐No Epilepsy	☐Yes ☐No Kidney issues	☐Yes ☐No Thyroid issues
☐Yes ☐No Bowel/ bladder issues	☐Yes ☐No Fatigue	☐Yes ☐No Hypoglycemia	☐Yes ☐No Vestibular disorders/Loss of balance
☐Yes ☐No Cancer	☐Yes ☐No Fever	☐Yes ☐No Lung issues	☐Yes ☐No Ulcers
☐Yes ☐No Chemical Dependency	☐Yes ☐No Head injury	☐Yes ☐No Osteoporosis	☐Yes ☐No Weight gain/loss

Please use the following lines to explain any circled above, or any medical problems not listed above:

_____

Please describe any injuries for which you have been treated (broken bones, dislocations, sprains, etc.) including dates:

_____

Have you ever had surgery? _____ If yes, please list reason and dates: _____
Is there any history of heart disease, diabetes or cancer in your family? ☐ Yes ☐ No If yes, please explain:

_____

Are you currently pregnant (or think you may be)? ☐ Yes ☐ No Past pregnancies? ☐ Vaginal ☐ Cesarean ☐ Other ☐ None

SOCIAL HISTORY

Do you smoke (#/day)? _____ Have you ever smoked? _____ When did you quit? _____

Do you exercise: _____If yes, how often? _____ types of exercise: _____

Have you been able to exercise despite your current injury? _____

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ABSOLUTE REHAB THERAPY PATIENT AGREEMENT

Please read and sign acknowledgement of this consent:

We appreciate your consideration in choosing Absolute Rehab Therapy for your rehabilitation needs, and we are committed to providing you with the best care possible. To achieve this, we need your assistance and understanding of our scheduling, cancellation, and financial policies.

Physical Therapy is a partnership between patient and therapist. At the onset of your care, we will discuss a recommended treatment plan, possible lifestyle changes, and a home exercise program to help facilitate your healing and achieving goals.

SCHEDULING AND CANCELLTION POLICIES

- Please schedule your appointments in advance. Our schedule fills up quickly and we want to ensure that you get the times that you need.
- Please be timely with your appointments. We will make every effort to respect your time, and we expect that you will do the same for both your therapist and your fellow patients. If you are late for an appointment, your one-on-one time with your PT will still end at the scheduled time. If you are more than 15 minutes late for an appointment, we will attempt to accommodate you for another time, but it may result in a cancellation fee of $100.
- Absolute Rehab Therapy realizes that many things arise in your busy schedules. That is why we allow for a 1-time courtesy on the cancellation fee. However, after that we require that you, please provide 24 hours' notice for cancellation or rescheduling of an appointment. Failure to comply will result in a cancellation charge of $100 due in full at your next visit. If you "no-show" or "late cancel" for 3 consecutive appointments, the fess will increase (see chart), and you will be removed from the schedule.
- Your insurance company will not pay for any cancellation charges due to missed appointments.
- **All scheduling and cancellations must be done in person or over the phone at the front desk.** Emails and texts should not be used for scheduling or cancellations as these are not checked regularly. Your physical therapist cannot schedule or cancel appointments for you.

_____
Initial

PAYMENT POLICIES

- **All treatment sessions, co-insurance, deductible and equipment payments are due at the time of service or via credit card on file for all patients.** Supplies and equipment purchased from Absolute Rehab Therapy as part of your treatment are not billable to your insurance, and since they are sold at cost, please pay with check or cash. For supplies, all payments must be in cash or check only.
- We accept Cash, Check, Debit and Credit Cards. A $35.00 service fee for the processing of any returned checks will be applied to your account.
- If payment is sent to you directly, please endorse the check to ART and provide us with a copy of the EOB.
- Any insurance policy deductibles or claims denied by your insurance carrier will be charged to your credit card once we have been sent proper notification by your major medical insurance carrier. A paid invoice and copy of the receipt will be sent to you for your records.
- Absolute Rehab Therapy reserves the right to charge interest at the legal prevailing rate and to apply late payments or service fees for multiple payment plans as necessary to manage the collection of your account.

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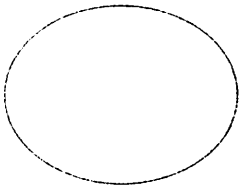

- There will be a 3% credit card processing fee automatically applied to all credit card and debit card transactions.

_____
Initial

INSURANCE POLICIES

- As a courtesy to you, we will verify your insurance coverage and benefits with your primary and secondary insurance carriers, with the understanding that verification is only a quote and not a guarantee of payment.
- Most insurance companies cover Absolute Rehab Therapy's services as an out-of-network provider providing your deductible has been met. Absolute Rehab Therapy will provide you with an insurance-readable bill to submit to your insurance company for reimbursement if you would like to self-submit. There are some insurance companies that we will bill directly on your behalf, determined on a case-by-case basis.
- Your insurance contract is an agreement between you, your employer, and your insurance company. We will render services on the assumption that charges will be covered by your insurance company. **However, you are ultimately responsible for payment for all services rendered**, unless otherwise provided by law. You will be responsible for all deductibles, coinsurance amounts, and services not covered by your insurance company, including those denied because the insurance deems them as "not covered", "not medically necessary", "not authorized", "maintenance", "not supported by documentation" or otherwise non-payable benefit.
- Not all services are covered benefits in all insurance contracts. Some insurance companies arbitrarily select certain services they will not cover. ***The fact that your insurance company may not pay for a particular item or service does not mean that you should not receive it.*** Your doctor and physical therapist determine your treatment plan based upon their educated opinions as to what is most appropriate care to get you better quickly. This includes, but is not limited to, evaluations, re-evaluations, electric stimulation, ultrasound, taping, therapeutic exercise, therapeutic activities, and neuromuscular re-education. We will do our best to work with you by utilizing the most traditionally covered codes by insurance companies.
- We will help by providing information to your insurance company necessary for them to process your claims, but we do not accept responsibility for settling the claim with your carrier. If you receive any denials or explanation of benefits from your insurance company, please notify us immediately for quicker processing.
- If payment is delayed, reduced, or denied by your insurance carrier beyond 90 days, you will be responsible for settling your balance with us.

_____
Initial

Absolute Rehab Therapy will be happy to assist you with any questions you may have regarding your account. Please contact our Office Manager, Monday- Friday from 8am to 4pm.

I have read the above information and agree with the financial, scheduling and cancellation policies of Absolute Rehab Therapy.

_____ _____ _____

Printed name of Patient or Guardian **Signature of Patient or Guardian** **Date**

3100 S. Federal Hwy, Ste A Delray Beach, FL 33483 Office: 561-241-4411 Fax: 561-241-4211
e-mail: absoluterehabtherapy@gmail.com

Absolute Rehab Therapy
A.R.T. in Motion

Patient Scheduling Preferences

Patient Name: _____

At Absolute Rehab Therapy, we do our best to accommodate your physical therapy appointments with your personal schedule. *Please understand your appointments are pertinent to your treatment plan in meeting your physical therapy goals.*

NOTE: The frequency of appointments can only be determined *after* completion of your initial evaluation. The frequency may be 3 times a week for the initial appointments, but will most likely be 2 times a week for the majority of your treatment plan.

Please fill out the schedule to designate your scheduling preferences, using the key symbols:

[X] Days/times in which you will be **NOT AVAILABLE**
[1] Your **1st** choice for appointment days/times (2 x week)
[2] Your **2nd** choice for appointment days/times (2 x week)

	Monday	Tuesday	Wednesday	Thursday	Friday
8:00am-9:00am					
9:00am-10:00am					
10:00am-11:00pm					
11:00pm-12:00pm					
1:00pm-2:00pm					
2:00pm-3:00pm					
3:00pm-4:00pm					
4:00pm-5:00pm					

If there are any ***specific dates* in which you will **not be available** (i.e.: vacations, doctor appointments) please write them below:

_____

_____

_____

Absolute Rehab Therapy
A.R.T. in Motion

Medical Record Release Form

I hereby authorize the following information to be released from the medical record of:

Patient Name: _____

DOB: _____

Address:

_____

_____

Phone #: _____

_____ **I request that my information be released to Absolute Rehab Therapy from**

Doctor Name/Name: _____

Fax #: _____

Requesting: _____ **Release of Insurance/Benefit information**

_____ **Medical Records**

_____ **Surgical Records**

_____ **MRI/CAT Scan Reports**

_____ **X-Rays**

_____ **Requesting updated prescriptions**

Signature _____ **Date:** _____

3100 S. Federal Hwy Ste A, Delray Beach, FL 33483 Office: 561-241-4411 Fax: 561-241-4211 e-mail: absoluterehabtherapy@gmail.com

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

We have a legal responsibility to focus on the privacy and security of your **Protected Healthcare Information (PHI)**. The federally mandated program, **Health Insurance Portability & Accountability Act of 1996 (HIPAA),** has set standards for the disclosure and protection of *individually identifiable health information* and any medical records related to those individuals. This Act gives you the right of understanding and controlling how your health information is being disclosed. In compliance with HIPAA, we are notifying you of our responsibilities and how we are required to maintain privacy of your records.

There are many different purposes of disclosing your personal information. Some disclosures require written authorization or consent; others are covered under the rights of HIPAA, after having made good faith efforts to obtain your acknowledgement of receipt of this notice. We may use or disclose your PHI for the following purposes: treatment, payment, and healthcare operations.

- **For Treatment** – sharing your PHI to provide, coordinate, or manage healthcare and related services with those healthcare providers that are involved in your care. For example, discussing your case with your referring doctor or other health care providers involved in your care.
- **For Payment** – sharing your PHI to obtain reimbursement for services provided to you, confirming coverage, billing and collection with your insurance company or other company that arranges or pays for some or all of your health care ("Your Payor").
- **For Health Care Operations** – sharing your PHI to operate our practice, including but not limited to, evaluating and assessing the quality of our services and health care professionals, or conducting improvement activities. We may also share your PHI for insurance related activities, legal services, and auditors to insure our compliance with the laws set before us. For example, an internal quality assessment review.

We are permitted to use or disclose your health information without further authorization from you for the following reasons:

- Required by law
- Required for public health purposes
- To report abuse or neglect
- Required by a health oversight agency for activities authorized by law to monitor the health care system, government programs and compliance with civil rights.
- For judicial and administrative proceedings when required by law
- For law enforcement purposes when required by law to do so
- Required by coroner, medical examiner, or funeral director
- Permitted by law for organ donor purposes
- Permitted by law for research purposes
- To prevent or lessen a serious or imminent threat to the health or safety of a person or the public
- Requested by military authorities if you are a member of the armed forces
- To comply with the laws relating to Workers' Compensation or other similar programs
- Required by your employer when you receive health care services at your employer's request to evaluate the medical implications of your workplace or to evaluate whether you have a work-related illness or injury.

FL State law provides additional protection for information regarding HIV/AIDS. We will continue to follow FL State law with respect to such information.

We may contact you by mail or phone to remind you of appointments or to provide information about events at Absolute Rehab Therapy. Unless you instruct us otherwise, we may leave a message for you on an answering device or with any person who answers the phone at your residence.

Other uses and disclosures will be made only with your written consent and authorization. Should you wish to revoke the authorization at any time, you may do so in writing and the sharing of your PHI will be stopped immediately.

Upon a written request from you, the patient, you are granted the following list of rights regarding your protected health information:

- The right to request limits regarding the disclosure of your PHI, specifically related to the sharing with family members, close friends, or any other person identified by you. Restriction requests do not apply to the uses that we are legally required or allowed to make.
- The right to request how PHI is communicated to you by our practice. We will agree to your request if it can be provided in an efficient manner.
- The right to inspect and copy your protected health information. Copies of PHI will be charged to you.
- The right to request a correction or update your PHI. If you should request a change of your PHI, you must do so in writing including a reason for the change being made. We will consider the reason for an amendment, but we are not required to agree to a change.
- The right to request and receive a list of disclosures of any PHI made by our office.
- The right to request and receive a paper copy of this notice at any time.

We are required by law to keep this notice updated to reflect any changes regarding the manner that PHI is disclosed. You may request a revised copy of this notice should it change at any time.

To File a Complaint: If at any time you feel your privacy rights have been violated or you have a complaint about our practice, you may file a written complaint to: Attn: Office Manager, Absolute Rehab Therapy, 3100 S. Federal Highway Suite A Delray beach Florida 33483. Your complaint or concerns will not alter or affect the quality of care provided to you by Absolute Rehab Therapy.

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, hereby understand and acknowledge receipt of Absolute Rehab Therapy Physical Therapy's Notice of Privacy Practices. I understand Absolute Rehab Therapy has reserved a right to change its privacy practices and that any revised copies of the Notice of Privacy Practices are available to me.

I give my consent to Absolute Rehab Therapy to release my PHI as the Notice states. I understand that I may revoke this agreement at any time by providing a written notice of my desire to do so to Absolute Rehab Therapy.

If you would like someone to make appointments for you, handle payment questions and/or be allowed to discuss your care with our office, please note their name here, and check any allowed communication that applies:

_____	_____	☐ appointments ☐ payment ☐ your care
Name	Relationship	☐ by phone ☐ by email
_____	_____	☐ appointments ☐ payment ☐ your care
Name	Relationship	☐ by phone ☐ by email

_____ _____ _____

Signature of Patient or Guardian **Name of Patient or Guardian** **Date**

<u>Consent for communication via e-mail with me, my referring physician and my insurance company</u>

I hereby consent to have my physical therapist from Absolute Rehab Therapy communicate via email with me, my referring physician and my insurance company regarding the following aspects of my medical care: appointments, progression or status of treatment, new or changing symptoms, determination of readiness to return to work, prescriptions, authorization or billing. I understand that email is not a guaranteed confidential method of communication. I further understand that there is a risk that email communications between my physical therapists and me or my referring doctor may be intercepted by third parties or transmitted to unintended parties. I also understand that any email communications between my physical therapist and me or my referring physician regarding my diagnosis or medical care will be printed out and made a part of my medical record. **I understand that in an urgent or timely situation, or for any scheduling needs, I should call** Absolute Rehab Therapy **directly and not rely on email.**

_____ _____ _____

Signature of Patient or Guardian **Date** **Email**

Absolute Rehab Therapy
A.R.T. in Motion

DIRECTIONS

Absolute Rehab Therapy
3100 S. Federal Hwy
Ste A
Delray Beach, FL 33483
Ph: 561-241-4411
Fax561-241-4211

From the North:
I-95 South or Jog Rd. to Linton Blvd
Take Linton East to Old Dixie Road or Federal Highway (US 1)– Take a RIGHT turn (south) onto Old Dixie Road or Federal Hwy.

To Lindell: Make a left into onto Lindell Blvd (Stop Light). We are in the Shoppes at Latitudes on the left. Entrance is in the middle of the building.

Federal Highway: Go South on Federal, make a RIGHT turn Lindell Blvd (Stop Light). We are in the Shoppes at Latitudes on the right. Entrance is in the middle of the building. We are on the 2nd floor right off the elevator.

South:
Take Congress Ave N and make a left-hand turn at SW 10th Ave. Take SW 10th Ave all the way down to Old Dixie Road. Take Old Dixie Road and pass Linton (traffic light). You will turn left onto Lindell Blvd. Entrance is in the middle of the building. We are on the 2nd floor right off the elevator.
Best for early AM or later PM appointments to avoid high volume traffic.

From the South
I-95 North to Yamato Road
Take Yamato East to N. Dixie Hwy – Take a LEFT turn (north) onto Dixie Hwy. About 2 miles up the road on the right you will see a traffic light Lindell Blvd, turn right. We are in the Shoppes at Latitudes on the left. Entrance is in the middle of the building. We are on the 2nd floor **LEFT** off the elevator.

**** Our office is located on the second floor right off the elevator in suite A.****