FLORIDA STRONG PHYSICAL THERAPY

PATIENT INFORMATION

LAST NAME:_____ FIRST NAME_____

DATE OF BIRTH:_____ AGE:_____ SEX_____ SS#_____

ADDRESS:_____ CITY:_____ STATE____ ZIP_____

PHONE:_____ DATE:_____ EMAIL:_____

PRIMARY CARE PHYSICIAN:_____ PHONE:_____

REFERRING PHYSICIAN:_____ PHONE:_____

PHARMACY NAME & ADDRESS_____

EMERGENCY CONTACT (NAME):_____ PHONE:_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:_____

INSURANCE ID#:_____ GROUP#:_____

SUBSCRIBER'S NAME:_____ DATE OF BIRTH:_____

SECONDARY INSURANCE COMPANY:_____

SECONDARY INSURANCE ID#_____GROUP#:_____

*IF PATIENT IS UNDER THE AGE OF 18, ENTER THE FOLLOWING INFORMATION

NAME OF PARENT/GUARDIAN RESPONSIBLE:_____

MOTHER'S NAME:_____ DATE OF BIRTH:_____

FATHER'S NAME:_____DATE OF BIRTH:_____

FLORIDA STRONG PHYSICAL THERAPY

MEDICAL HISTORY

REASON FOR THERAPY:_____

IS THIS DUE TO AN ACCIDENT? YES☐ NO☐ IF YES,WHEN?_____

HAVE YOU BEEN TREATED FOR THIS CONDITION PREVIOUSLY? YES☐ NO☐

IF YES, BY WHOM?_____

PLEASE LIST ANY ALLERGIES:_____

_____

PLEASE LIST CURRENT MEDICATIONS:_____

_____

_____

_____

PAST MEDICAL HISTORY (CHECK ONLY WHAT APPLIES)

☐ AIDS/HIV ☐ ANGINA ☐ ANXIETY ☐ ARTHRITIS ☐ ASTHMA

☐ AFIB ☐ BIPOLAR DISORDER ☐ BLOOD CLOTS ☐ BREAST DISORDER

☐ CANCER ☐ CHRONIC FATIGUE ☐ CONGESTIVE HEART FAILURE

☐ COPD ☐ DEPRESSION ☐ DIABETES ☐ DVT ☐ FIBROMYALGIA

☐ GASTROINTESTIONAL BLEED ☐ GLAUCOMA ☐ GOUT ☐ HEADACHES

☐ HEART DISEASE ☐ HEARTBURN/REFLUX ☐ HEPATITIS ☐ STROKE

☐ HIGH BLOOD PRESSURE ☐ HIGH CHOLESTEROL ☐ KIDNEY STONES

PAST MEDICAL HISTORY: CONTINUED

☐ HEART ATTACK ☐ OSTEOPOROSIS ☐ SEIZURES ☐ STOMACH ULCERS

☐ THYROID DISEASE

PLEASE LIST ALL PAST SURGICAL PROCEDURES AND YEAR:_____

_____

_____

TOBACCO USE:YES☐ NO☐ FORMER SMOKER____

CANCELLATION POLICY: We request that you please give our office at least 24-hour notice in the event that you need to reschedule/cancel your appointment. If you do not provide us with a 24-hour notice, or if you do not show up for a scheduled appointment, you may be charged a $50.00 fee. Additionally, you may be offered limited appointment times. Repeated offenses with result in dismissal from the practice.

SIGNATURE:_____ DATE:_____

INFORMED CONSENT TO TREATMENT

I certify that I am the patient or legal guardian listed above. I have read and understand the included information and certified to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this business of physical therapy. I authorize this office and staff to examine and treat my condition as a doctors see fit. I hereby authorize the doctors/staff to release all my information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that the health insurance policies are in arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Patient Signature:_____

Date:_____

NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The patient understands that: Protected health information may be disclosed or used for treatment, payment, or health care operations. The Practice has Notice of Privacy Practices and that the patient has the opportunity to review this Notice. The practice reserves the right to change the Notice of Privacy Practices. The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions. The patient may revoke this Consent in writing at any time and all future disclosures will then cease. The Practice may condition receipt of treatment upon the execution of this Consent.

SIGNATURE: _____

DATE: _____