Absolute Rehab Therapy

Patient Registration
(PLEASE PRINT CLEARLY)

Today's Date: _____

Patient's Name: Last _____ First _____ MI ____

Date of Birth: ____/____/_____ Age: _____ Sex: M ☐ F ☐

Primary Address: _____ City: _____ State: _____

ZIP: _____

Mailing Address (if different from above): _____ City:

_____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

Email: _____@_____

How would you like to be Notified of your appointments? Email ☐ Voicemail ☐ Text ☐

How did you hear about us?

☐ Doctor Referral ☐ Insurance Company Referral

☐ Referred by Friend (please name here): _____

☐ Self-Referred (Walk-In, Internet)

☐ Other: _____

Have you had Physical Therapy or Home Health this current year? ☐ No ☐ Yes

If yes, Name of agency: _____ Last date seen? _____

Have you been involved in an Automobile accident within the last year? ☐ No ☐ Yes

Do you have an attorney representing you? ☐ No ☐ Yes If Yes, who? _____

Insurance Information

Primary Insurance: _____ ID#: _____

Secondary Insurance: _____ ID#: _____

Workers Compensation

Employer: _____ Phone: _____

Case Manager: _____ Phone: _____

Attorney? ☐No ☐Yes Attorney Name: _____ Phone: _____

Patient Name (please print): _____

Patient Signature: _____ Date: _____

6971 N. Federal Hwy, Suite 305, Boca Raton, FL 33487 Office: 561-241-4411 Fax: 561-241-4411
e-mail: absoluterehabtherapy@gmail.com

Absolute Rehab Therapy

Medical History
(PLEASE PRINT CLEARLY)

Name: _____

Have you had, or currently have any of the following? Please Mark ONLY if yes

MEDICAL HISTORY

Allergies ☐	Gallbladder Problems ☐	Nausea ☐
Anemia ☐	Gout ☐	Numbness ☐
Anxiety ☐	Headaches ☐	Osteoporosis ☐
Arthritis ☐	Hepatitis ☐	Pacemaker ☐
Asthma ☐	Hearing Difficulty ☐	Parkinson's ☐
Blood Clots ☐	Heart Attack ☐	Rheumatoid Arthritis ☐
Cancer ☐	Hernia ☐	Seizures ☐
Cardiac Condition ☐	High Blood Pressure ☐	Sinus Problems ☐
Circulation Problems ☐	High Cholesterol ☐	Sleeping Disorders ☐
Currently Pregnant ☐	Infectious Disease ☐	Smoker ☐
Dementia ☐	Joint Replacements ☐	Speech Problems ☐
Depression ☐	Kidney Disease ☐	Strokes ☐
Diabetes ☐	Liver Disease ☐	Thyroid Disease ☐
Dizzy Spells ☐	Loss of Balance ☐	Tuberculosis ☐
Emphysema ☐	Low Blood Pressure ☐	Vision Problems ☐
Epilepsy ☐	Metal Implants ☐	Weakness ☐
Fibromyalgia ☐	Multiple Sclerosis ☐	

Please list any other conditions that are not listed here on the back or a separate sheet of paper

COVID Vaccination:

Have you had the COVID Vaccination ☐ Yes ☐ No
Date of First Vaccination: _____
Date of Second Vaccination: _____

Fall History

Injury as a result of a fall in the past year? ☐ Yes ☐ No Date of fall: _____
Two or more falls in the last year? ☐ Yes ☐ No Date of falls: _____

Surgical History

Body Region: _____ Surgery Type: _____ DOS: _____
Body Region: _____ Surgery Type: _____ DOS: _____
Body Region: _____ Surgery Type: _____ DOS: _____

List additional surgeries on back or separate sheet of paper

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Medical History

(PLEASE PRINT CLEARLY)

Current Medications

Drug: _____ Dosage: _____ Reason for Taking: _____

Drug: _____ Dosage: _____ Reason for Taking: _____

Drug: _____ Dosage: _____ Reason for Taking: _____

Drug: _____ Dosage: _____ Reason for Taking: _____

List additional medications on back or separate sheet of paper

Allergies

_____

_____

Patient's Signature: _____ Date: _____

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Medical Screen

Patient Name: _____ **D.O.B:** ____/____/_____

Sex: ☐M ☐F **Height:** _____ **Weight:** _____ **Blood Pressure:** _____/____mmHg

Where are you currently having symptoms?

_____

Date of injury or onset of symptoms? _____

Have you been treated for this/these problems in the past? ☐Yes ☐No if yes, when and where? _____

Have you had surgery related to this/these problems in the past? ☐Yes ☐No if yes, type and date: _____

Have you had any of the following Medical/Rehabilitation services for this problem? (Check ALL that apply)

☐ Chiropractor	☐ MRI	☐ Orthopedist
☐ CT Scan	☐ Myelogram	☐ Physical Therapist
☐ ER Care	☐ Neurologist	☐ Podiatrist
☐ Massage Therapy	☐ Occupational Therapist	☐ X-Ray

Are you aware of what your diagnosis is? ☐Yes ☐No if yes, what: _____

Based upon your awareness, what are your expectations/goals? (i.e.: improve ability to....;decrease pain with...)

Type of pain (Check maximum of 2):

☐ Aching	☐ Sharp
☐ Burning	☐ Shooting
☐ Dull	☐ Other

Please check ALL that apply below:

☐ Headaches: _____x/week
☐ Numbness
☐ Tingling
☐ Weakness

Frequency of Pain *How often do you have this pain?*

_____x/week ☐ every A.M ☐ every P.M With Activity? ☐Yes ☐No

Intensity of Pain *Please indicate which number best describes your pain intensity: #* _____

My pain is increased by:

_____

My pain is decreased by:

_____

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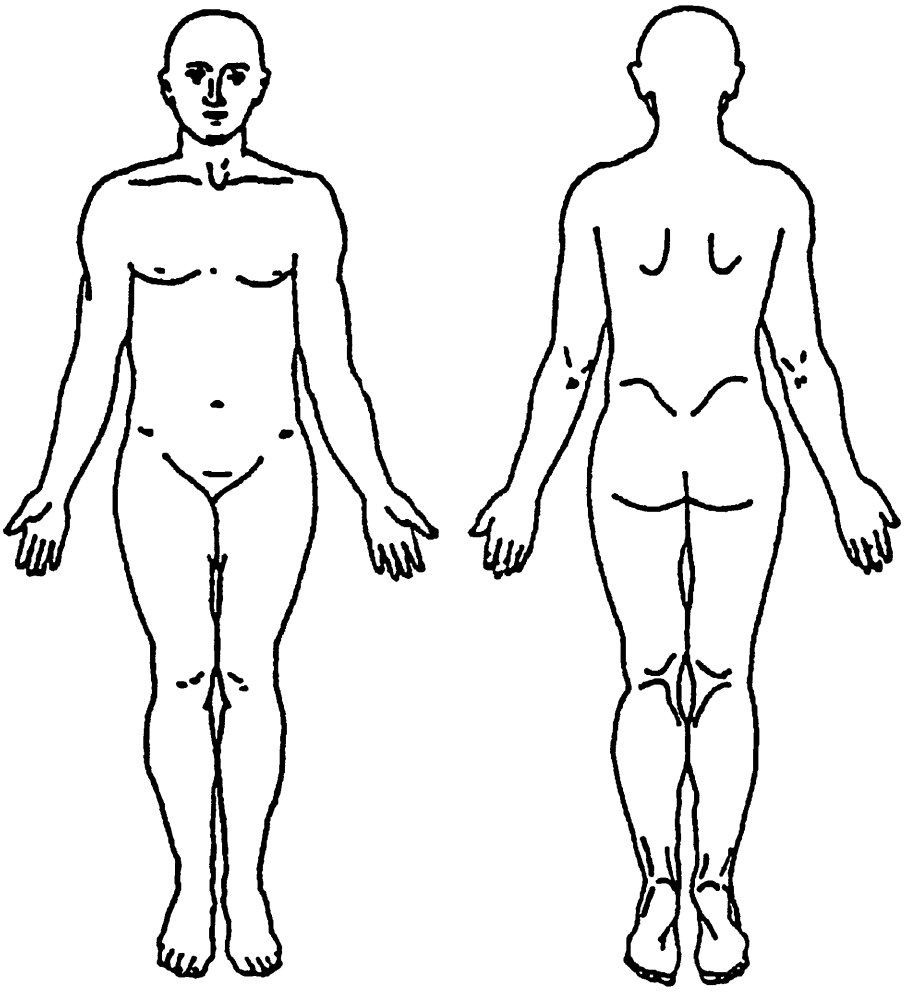

Pain/Symptoms

- Please mark your pain on an average day by marking a number on the scale below.

0----------10
No Pain **ER Visit**

- On the Body Diagram above, describe your symptoms using the following symbols:

(X) Sharp (+) Numb/Tingling (#) Ache (B) Burning

Patient's Signature: _____ Date: _____

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Consent for Care and Treatment

Your Physical Therapist will complete an evaluation by examination and interview. Your individual treatment program will then be designed. A variety of treatment techniques may be used.

› **I, the undersigned, do hereby agree and give my consent for Absolute Rehab Therapy to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical conditions.**

› **INITIAL** _____

- **Workers Compensation Claims:** Prior authorization/approval is needed before any treatment or therapy can be performed. Failure to have proper authorization may result in your claim for Workers Comp benefits being denied and you will be held responsible for the total charges or fees for services rendered.
- **PIP Claims:** (Auto Insurance) Your auto insurance commonly covers 80%/ The remaining 20% will be billed to you once the claim is processed and paid for you by insurance. If your benefits have been exhausted, your claims will be billed to your insurance company. If your claim is part of a law suit, the 20% will be held over until the case settles and payments are then determined by a negotiation process.

› **INITIAL** _____

❖ **FINANCIAL POLICY:**

You are responsible for your bill, as we are out of network on all insurances other than Medicare. We will bill your personal insurance carrier solely as a courtesy to you. If you change insurance coverage while undergoing treatment, it is your responsibility to notify the office of this change. If your insurance carrier does not remit payment to us within 60 days, the balance owed will be due in full from you. In the event that your insurance company requests a refund of payments made to us, you may be responsible for the amount of money refunded to your insurance company. If the insurance company for services billed by us make any payment directly to you, you recognize an obligation to promptly remit the payment(s) to us. If formal collection procedures become necessary you will be responsible for additional costs incurred. Your insurance policy is a contract between you and your insurer and most information regarding your benefits are located in your plan booklet or you can check with your insurance company. We assume no liability for any errors made by your insurance carrier.

We will verify your insurance benefits and coverage on your behalf but please note that benefits and coverage is not a guarantee of payment and you are ultimately the responsible party of all fees for services rendered.

- **CO-PAYMENTS:** Co-payments are due at the time of service unless prior arrangements have been made in writing.
- **INSUFFICIENT FUNDS:** Checks returned for insufficient funds may be subject to a **$35.00** processing fee.

› **CANCELLATION and NO-SHOW POLICY:** We require 24 hours' notice in the event of a cancellation. The charge for cancellation without prior notice is $65.00. This charge will not be covered by insurance but will have to be paid by you personally prior to receiving additional treatments.

Patient Name: _____

Patient Signature: _____ **Date:** _____

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Cancellation Policy

We understand that unanticipated events happen occasionally when one might consider cancelling an appointment. Absolute Rehab Therapy strives to provide each patient with the highest quality of care while attempting to accommodate your schedule for your convenience. Failure to keep your scheduled appointments hinders our ability to provide the best care to our patients.

Our automated appointment reminder system graciously gives our patients 48 hours' notice of their next scheduled appointment either by text, voice call, or email. Please do not respond to these reminders as we do NOT receive the responses to them. If you need to make changes, please call our office at (561)-241-4411 to do so.

We require 24-hour notice to re-scheduling or cancel an appointment; otherwise, the fee for less than 24-hour notice is $65.00. You will only be charged if you do not provide appropriate notice for your cancellation. This allows us the opportunity to offer that time slot to another patient (from our waiting list) and allows us to re-schedule your appointment, so that you do not miss out on your visits. We must ask your full cooperation!

Anyone who either forgets or consciously chooses to forgo his or her appointment for whatever reason will be considered a **no-show** and will be charged the **full treatment session**, and further services will be denied until payment is made.

Appointment times have been arranged specifically for you. If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours.

When you do not keep your appointment, three people are hurt:
You-Because you are not receiving the treatment you need.
The Therapist-Who has an open space in the schedule, which was reserved for you
Other Patients-That could have been scheduled if you had given our office proper notice.

I have read and understand the attendance-cancellation policy. By signing this you acknowledge and agree to be bound by its terms.

Please indicate how you would prefer to be alerted for your appointments:

O Text _____ **O Voice call** _____ **O Email**_____

Signature _____ Date _____

Print Name _____

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:** _____

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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

DIRECTIONS

Absolute Rehab Therapy
6971 N. Federal Highway Ste 305
Boca Raton FL 33487
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.

From Old Dixie: Go Past Lindell AND Hidden Valley (Both are Traffic Lights). Make a left into 6971 **Boca Palm Professional Plaza.**

From Federal: Go Past Lindell AND Hidden Valley (Both are Traffic Lights). Make a RIGHT turn into 6971 **Boca Palm Professional Plaza** (Entrance is between Tuscany Condominiums and building 7001. We are directly across the street from ABC Liquor

Alternate North Route:
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, Lindell AND Hidden Valley (Traffic Lights). 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 1 mile up the road on the right just past the Tuscany condominiums and right before Old Dixie Seafood–
Take a RIGHT turn into 6971 **Boca Palm Professional Plaza**

**** Our office is located on the ground floor.****

A map can be found on our website:www.absoluterehabtherapy.com The link indicating '*office location*' can be found at the top of the page.