410 N. Palafox Street
Pensacola, FL 32501
P: 850-332-7681
F: 850-512-1188

PATIENT INTAKE FORM

Name: _____ ***Date of Birth:*** ___/___/_____

Preferred Name: _____ ***Social Security #:*** _____-_____-_____

Local Address: _____

City: _____ ***State:*** _____ ***Zip Code:*** _____

*(Please check preferred method of contact)

☐ ***Home Phone:*** _____-_____-_____

☐ ***Cell Phone:*** _____-_____-_____ (Does cell phone have Text Ability: Yes / No)

☐ ***Email Address****: _____

***(Used for mailing purposes and Home Exercise Programs)**

Occupation: _____

Place of Employment: _____

Primary Insurance: Name: _____ ***Policy #:*** _____

Secondary Insurance: Name: _____ ***Policy #:*** _____

Tertiary Insurance: 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:*** _____

HOW DID TOU HEAR ABOUT US?

___ Doctor Referral _____
___ Social Media
___ Radio commercial
___ TV Commercial
___ Friend Referral _____
___ Internet search
___ Walk-In
___ Other _____

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CONFIDENTIAL MEDICAL HISTORY FORM

NAME: _____ ***Injury or Reason for Visit:*** _____

When did Symptoms begin? _____ ***(approx.) Diagnostic Testing Done?*** (x-rays, MRI, etc) _____

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

Surgery for this condition? Yes / No ***Date of Surgery?*** ____/_____/_____

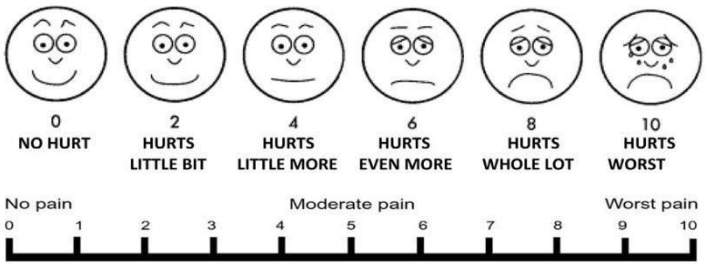
Hospitalization for this condition? Yes / No ***Date of Hospitalization?*** From: ___/___/____ To: ___/___/____

Are you having Pain? Yes / No (0-10)

If so, What is it Currently? _____

At worst? _____

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

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FINANCIAL AGREEMENT

PAYMENT POLICY: Payment is due at the time services are rendered. If you have insurance, your estimated portion plus deductible is due at the time of service. If no insurance is involved, payment is expected at each visit. 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 can be construed as fraud. We accept cash, personal checks with proper ID, credit cards, debit cards, HSA and FSA cards. If there is a balance and charges have been on the account for over 90 days, your account will be subject to a collection agency and all costs incurred will be your full responsibility (Attorney costs, collection agency fees, court fees, etc.). Fees will apply for a returned check.

INSURANCE: As a courtesy to you, our staff will verify your insurance and notify you of the information they receive. You must provide accurate and current insurance information. It is your responsibility to be familiar with your 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. Your insurance policy is a contract between you and the insurance company. We are NOT a party to that contract. All charges not paid by your insurance company are YOUR responsibility regardless of the reason for non-payment. We will provide you with the most accurate information, but we CANNOT guarantee your out-of-pocket expenses. If you have a change in insurance carrier during your treatment, it is your responsibility to inform us. Failure to do so can result in denials from the insurance company which you will be responsible for. We will do our best to keep you updated of charges and balances left on your account.

BROKEN APPOINTMENTS: If you find it necessary to cancel or reschedule an appointment, **we require a 24-hour advance notice in order for you to avoid a fee up to $50.00** (Fee based on number of appointments missed). Missed or broken appointments prevent others from receiving the physical therapy they need. The appointment you have is specifically yours and we understand that sometimes a missed or broken appointment is unavoidable, therefore, to enforce this policy we charge a fee. A "no-show" is an appointment that is not cancelled with 24-hour advance notice. This is NOT covered by insurance and will be billed to the patient. We are obligated to report all no-show and cancellations to your doctor and the involved insurance companies. Workers' compensation patients must take extra precautions in attending physical therapy as treatment can be disrupted for non-compliance. Non-compliance may result in termination from our practice.

ACKNOWLEDGEMENT: I have read the above, and I 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 for notifying 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 of Patient (or parent/guardian if minor)	Relationship to patient	Date

Revised 5/30/2024

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CONSENT TO TREAT:

I, _____, hereby agree and give my consent to receive medical treatment for my physical condition. I authorize the release of any medical information needed to process my claim to those with a need-to-know basis. This may include other healthcare providers, lawyers, or anyone that the patient requests information to be sent to . **I authorize release of payment to LEGENDARY PHYSICAL THERAPY, LLC.** regardless of participation in or out of network.

Signature of Patient (or parent/guardian if minor)	Relationship to patient	Date

NOTICE OF PRIVACY PRACTICES - PATIENT ACKNOWLEDGEMENT

I have received, reviewed and understand the practice's Policy on Privacy Practices. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise my rights, and the practice's legal duties with respect to my information. I acknowledge that I have received, read and understand the NOTICE OF PRIVACY PRACTICES.

I understand that this practice reserves the right to change the terms of it's Notice of Privacy Practices, and to make changes regarding all protected health information resident at or controlled by this practice. If changes to the policy occur, this practice will provide me with a revised Notice of Privacy Practices upon request.

Signature of Patient (or parent/guardian if minor)	Relationship to patient	Date

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HIPAA PRIVACY POLICIES

It is the policy of ***Legendary Physical Therapy and Wellness*** that all providers and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its providers and staff have all the necessary medical and PHI to provide the highest quality physical therapy care possible while protecting our practice and its provider and staff or purposes of treatment, payment, and healthcare operations (TPO), knowing that our practice and its providers and staff will--

- Adhere to the standards set forth in the Notice of Privacy Practices
- Collect, use, and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorizations, as appropriate. Our practice and its providers and staff will not use or disclose PHI for uses outside of practice's TPO, such as marketing, employment, life insurance applications, etc. without authorization from the patient.
- Use and disclose PHI to remind patients of their appointments only with their consent.

Recognize that PHI collected about patients must be accurate, timely, complete, and available when needed. Our practice and its providers and staff will:

- Implement reasonable measures to protect the integrity of all PHI maintained about patients.
- Recognize that patients have a right to privacy. Our practice and its providers and staff always respect the patient's individual dignity. Our practice and its providers and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.

Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice and its providers and staff will:

- Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.
- Not disclose PHI data unless the patient (or his or her authorized representative) has properly consented to or authorized the release or the release is otherwise authorized by law.

Recognize that, although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her medical record if he/she believes his/her information is inaccurate or incomplete. Our practice and its providers and staff will --

- Permit patients access to their medical records when their written requests are approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site healthcare professional review the patients' appeals.
- Provide patients an opportunity to request correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.

All providers and staff of our practice will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice.

All providers and staff of our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.

Our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request.