Florida Physical Therapy Specialists
Patient Registration
ALL QUESTIONS MUST BE ANSWERED

TODAY'S DATE _____

Name: _____ **Date of Birth**: _____ **Sex: M F**
Local Address: _____City_____ St _____Zip_____
Northern Address: _____City_____ St_____ Zip_____
Primary Phone # _____ **Alternate #** _____
May we leave a message on your voicemail? YES_____ NO _____

Email Address:_____
May we use your email to send valuable information about our office? Yes _____ No _____

Emergency Contact: Name: _____ **Relationship:** _____
Phone Number: _____

PERMISSION TO VERBALLY DISCUSS PROTECTED HEALTH INFORMATION:
NOBODY AT THIS TIME: _____ -OR-
Name: _____ **Relationship to Patient:** _____
Phone Number: _____

Is this injury WORK RELATED?_____AUTO ACCIDENT? _____ Date of Injury? _____
If yes, please explain: _____

HOW DID YOU HEAR ABOUT OUR CLINIC?
I'm A Previous Patient_____ Referring Physician_____ Employer _____ Walk-In _____
Friend (friends Name: _____) Newspaper _____ Internet ____ Other_____

INSURANCE INFORMATION:
Name of Primary Ins_____
Name of Secondary Ins_____

GUARANTOR INFORMATION: If a minor or someone other than yourself.
Name: _____ Phone # _____
Address:_____

Assignment of Benefits – Privacy Acknowledgment
I authorize payment directly to Doctors Choice Physical Therapy, at Florida Physical Therapy Specialists.
This is a direct assignment of benefits under my policy.
I have received, or read in the office, a copy of the Notice of Privacy Practices for Florida Physical Therapy Specialists. I consent to the use and disclosure of my personal health information for the purpose of treatment, payment, and health care operations.

Signature:_____ **Date**: _____

FLORIDA PHYSICAL THERAPY SPECIALISTS

Medical History Questionnaire

Name: _____ **Today's Date:**_____

PRIMARY PHYSICIAN'S Name:_____

Physician who referred you to us: _____

Do you have, or have you previously ever had:

___Yes___No Rheumatic Fever
___Yes___No Heart Murmer
___Yes___No High blood pressure
___Yes___No Angina or chest pain
___Yes___No Heart Attack
___Yes___No Abnormal EKG
___Yes___No Other heart trouble
___Yes___No Diabetes
___Yes___No Arthritis
___Yes___No Disease of the arteries
___Yes___No Varicose veins
___Yes___No Asthma
___Yes___No Lung Disease
___Yes___No Back Injury
___Yes___No Epilepsy
___Yes___No Gout
___Yes___No Surgeries

___Yes___No Chest pain
___Yes___No Shortness of breath
___Yes___No Dizziness, faintness, or loss of consciousness
___Yes___No Heart Palpitations
___Yes___No Cough on exertion
___Yes___No Kidney problems
___Yes___No High cholesterol
___Yes___No Breathlessness at rest
___Yes___No Coughing up blood
___Yes___No Disability of feet, ankles, knees, hips, and/or neck
___Yes___No Swollen and stiff painful joints

If you checked YES to ANY of the above past medical history, PLEASE EXPLAIN:

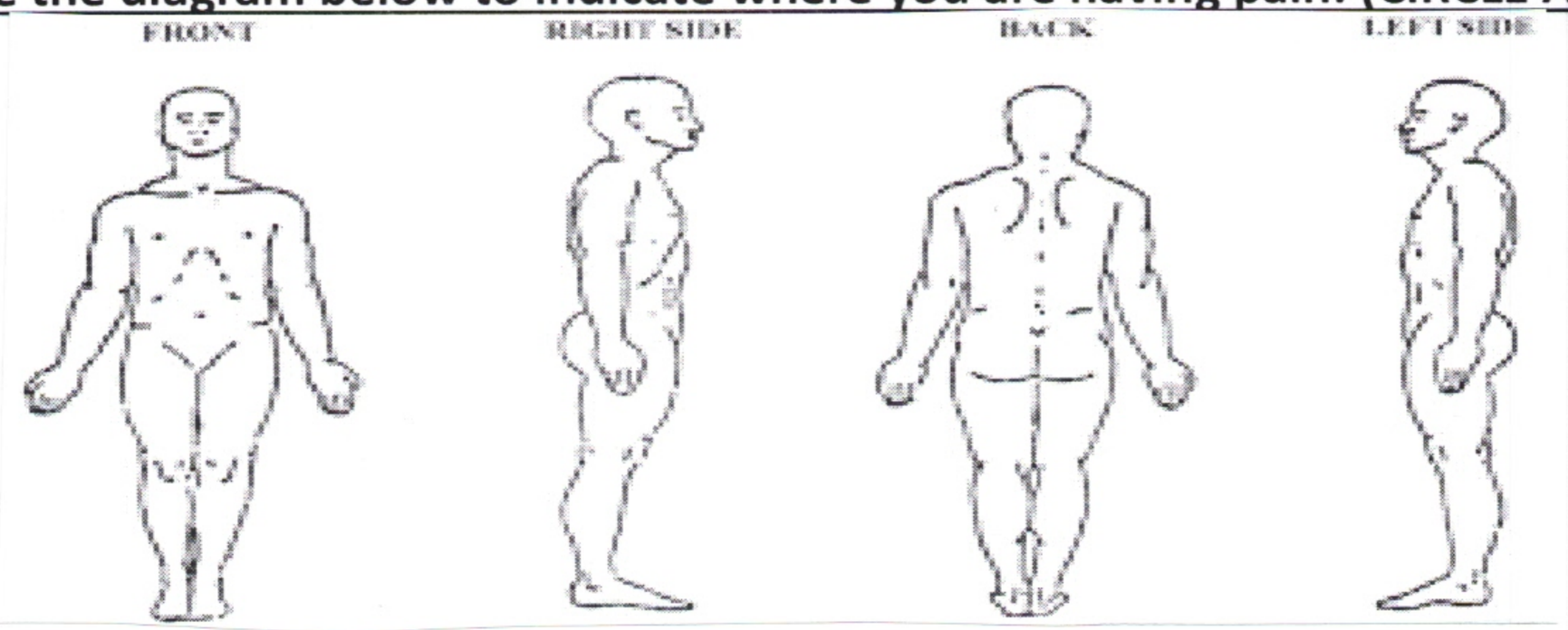
_____
_____
_____
_____

Do you have any medical problems that would limit your ability to exercise? ___Yes ___No

If Yes, please explain why it affects you from exercising:

_____
_____
_____

Use the diagram below to indicate where you are having pain: (CIRCLE AREAS)



1. When did your symptoms begin? _____

2. Circle the words that best describe your symptoms:
   Aching Burning Tingling Stabbing Throbbing Numbness

3. Are your symptoms due to an accident or trauma? Yes_____ No _____
   If yes, describe: _____
   _____
   _____
   _____

4. What makes you feel better? _____
   What makes you feel worse? _____

5. Please list any diagnostic testing you have had prior to todays visit
   (X-Rays, MRI, CT SCAN, Myelogram, etc):
   _____

6. Circle the intervention you have done prior to this visit:
   Injections Splint Medications Previous Physical Therapy Surgery

7. **List ALL CURRENT MEDICATIONS, including STRENGTH and DOSAGE:**

Name of Prescription	***Strength***	***Dose***
1.		
2.		
3.		
4.		
5.		
6.		
7.		

FLORIDA PHYSICAL THERAPY SPECIALISTS

Thank you for choosing us as your Physical Therapy provider. We are honored by your choice and are committed to providing you with the highest quality healthcare.

Please read and sign this form to acknowledge your understanding of our patient financial policies.

PATIENT FINANCIAL RESPONSIBILITIES:

- **The patient (or patients guardian, if a minor) is ultimately responsible for the payment for his or her treatment of care.**

- **We are pleased to assist you by filing visits to both your primary and secondary insurance carriers. Patients are required to provide us with ACCURATE and CURRENT insurance information and are responsible for any charges incurred if the information provided is not up to date.**

- **Patients are expected to have knowledge about their specific insurance benefits and coverage, such as remaining deductibles, specialist office visit co-pays, and co-insurances, as well as all other procedures or treatments that may or may NOT be covered by your insurance plan. We do NOT verify any secondary insurances, nor will we obtain any pre-authorizations from a secondary plan. If you have any questions regarding what your primary or secondary insurances pay, please refer to the Member Services phone number listed on the back of your insurance ID cards.**

- **Patients are responsible to pay any monies due at the time of service. If an insurance is verified after the initial visit, you will be responsible to pay the monies due at the next visit. If it is not collected at that time, you will receive a bill for services for the attended date(s) of service. For your convenience, we accept cash, check, and most major credit cards at the office and over the phone.**

I AGREE TO THE PROVISIONS OF THIS PATIENT FINANCIAL RESPONSIBILITY FORM:

_____

Signature of Patient/Guardian **Date**

FLORIDA PHYSICAL THERAPY SPECIALISTS

IMPORTANT NOTICE TO OUR PATIENTS ABOUT HOME HEALTH CARE OR SKILLED NURSING CARE AND PHYSICAL THERAPY.

If you are currently, or at any time during the last several months, under the care of a home health care agency or skilled nursing facility (if a nurse or health care professional comes to your home, or you went to a skilled nursing facility for care) please inform us immediately.

IF you are also under the care of a home health care agency or skilled nursing agency during your treatment with Florida Physical Therapy Specialists, Medicare WILL NOT PAY for physical therapy at an outpatient facility (Florida Physical Therapy Specialists), and you will be responsible for your bill**. Medicare only pays if you are NOT also seeing at the same time, a home health therapist or nurse in your home.**

If at ANYTIME DURING YOUR PHYSICAL THERAPY TREATMENT, you have ANYONE come to your home to help you with bathing, medications, wound care, learning self injections, cleaning, cooking or any activity of your daily living, you **MUST** inform us immediately.

Please write your initials below acknowledging you have read and understand the above. Thank you.

_____ _____

Patient Initials Date