**FYZICAL THERAPY AND BALANCE CENTERS OF SANIBEL**

Therapist \_\_\_\_\_\_\_\_\_\_Date of First Appt. \_\_\_\_\_\_\_\_\_\_\_ Date of RX\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Last Name First M. I. Date of Birth | |
| Florida Address City State Zip Florida Phone# | |
| Out of state addressCity State Zip Phone# | |
| Cell Phone # Okay to Text: Yes No Email Address: Okay to email: Yes No | |
| Social Security # Sex M/FMarital Status S M W D | |
| StWor Work Status - EmployedStudentRetiredVolunteer Disabled Unemployed  Employer Address: | |
| Have you had therapy anywhere else this year? Yes No | |
| Have you received home health services during the last three months? Yes No  If yes, name of agency and phone: | |
| Onset of symptoms/Date of Injury/Accident: | |
| If Accident Related – Attorney Name/Address: | |
| Emergency  Contact Relationship Phone | |
| **\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*FOR OFFICE USE ONLY\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*** | |
| Primary Insurance Company | Secondary Insurance Company |
| Name | Name |
| Name of Policy Holder | Name of Policy Holder |
| Identification # | Identification # |
| Group Name or # | Group Name or # |
| Date of Birth | Date of Birth |
| Diagnosis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ICD10 Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Referring MD | NPI# |
| Telephone | Fax |

**SUBJECTIVE EVALUATION FORM**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_**

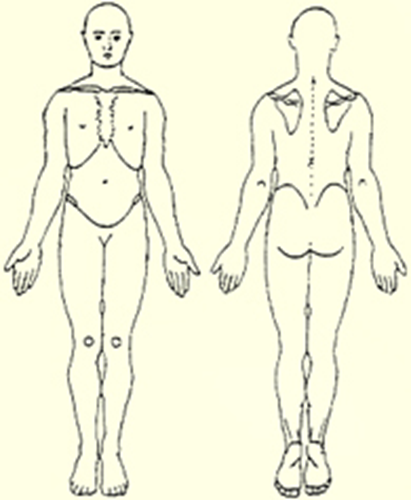
**Diagnosis/Complaint:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Symptoms:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Injury / Onset / Surgery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Tests: X-RAYS MRI CT EMG Bone Scan Arthrogram**

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**What Increases Symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What Decreases Symptoms? (Position/activity) \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Describe pain: (Circle) Sharp Dull Ache Shooting Stiffness**

**Rate Pain on a Scale of 1-10, 0- No Pain, 10-Worst Pain you can imagine.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Any past problems of this nature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mark areas of pain/tightness/discomfort Do you have a pacemaker? (Circle) Yes No**

**Do you take corticosteroids or anticoagulants?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical History (circle): Alzheimer’s/Dementia - Cardiovascular Disease - Diabetes - Fibromyalgia - High Blood Pressure - Cancer - Huntington’s - Lupus Osetoarthritis - Parkinson’s Disease - Rheumatoid Arthritis - Thyroid Disease -**

**Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Surgical History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What do you hope to achieve through therapy?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FYZICAL THERAPY AND BALANCE CENTERS OF SANIBEL**

**HIPPA RELEASE OF INFORMATION FORM**

Authorization for use and or disclosure of Protected Health Information (PHI). Required by the Health Insurance Portability and Accountability Act.

1. I ,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize Fyzical Therapy and Balance Centers of Sanibel to release my medical information to me and to the following individual(s) in my presence and when I *am not* physically present, including disclosures by telephone, voice mail, facsimile, e-mail, or regular mail.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Patient: \_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Patient: \_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Patient: \_\_\_\_\_\_\_\_\_\_

1. I hereby authorize the release of PHI as follows (circle one):

A: my complete health record. B: my complete health record *with the exception of the following information* (circle as appropriate). 1. Mental health records. 2. Communicable diseases (including HIV/AIDS) 3. Alcohol/drug abuse treatment 4. Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
2. I understand I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.
3. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

**IT IS MY UNDERSTANDING THAT BY SIGNING THIS AUTHORIZATION FOR RELEASE OF MY RECORDS; I AM GIVING PERMISSION TO FYZICAL THERAPY AND BALANCE CENTERS OF SANIBEL TO FURNISH COPIES OF MY MEDICAL INFORMATION AS DESCRIBED ABOVE TO THE ABOVE NAMED INDIVIDUALS.**

**THIS CONSENT WILL EXPIRE IN ONE (1) YEAR FROM THE DATE BELOW OR SOONER AT MY ELECTION.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient, Parent, or Legal Guardian/Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Date

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT,

AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Fyzical Therapy and Balance Centers of Sanibel for the purpose of providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of Physical Therapy of Sanibel. I understand that treatment of me by Fyzical Therapy and Balance Centers of Sanibel may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Fyzical Therapy and Balance Centers of Sanibel is not required to agree to the restrictions that I may request. However, if Physical Therapy of Sanibel agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that Fyzical Therapy and Balance Centers of Sanibel has taken action in reliance on this consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a healthcare clearinghouse. This protected information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that I have the right to review Fyzical Therapy and Balance Centers of Sanibel’s Notice of Privacy Practice prior to signing this document. Fyzical Therapy and Balance Centers of Sanibel’s Notice of Privacy document will be provided to me upon my request. The Notice of Privacy Practices document describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of Physical Therapy of Sanibel. It also describes my rights and Fyzical Therapy and Balance Centers of Sanibel’s duties with respect to my protected health information.

Fyzical Therapy and Balance Centers of Sanibel reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices upon request.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Person Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Patient or Personal Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of Personal Representative’s Authority

**Patient Responsibilities**

Welcome to Fyzical Therapy and Balance Centers of Sanibel. We provide physical therapy services and our staff is committed to providing optimal care for each patient through treatment plans and patient/family education. We wish to acquaint you with our policies and procedures in order to serve you better.

**Office Hours:** Monday through Friday from 9:00 am until 5:00 pm. Clinical hours may vary according to therapist schedule. If calling before 8:00 am or after 5:00 pm, please leave a message on our answering machine.

**Scheduling:** While every attempt is made to maintain a consistent schedule that is amenable to each patient, variables such as a patient requiring specific equipment and/or individual therapist caseload may result in schedule changes. We cannot guarantee that each week your schedule will remain constant **– please check your schedule each week.** Your understanding and cooperation is appreciated.

If you have had previous difficulty remembering your schedule and would like a “reminder” call, please speak with our office, arrangements will be made to assist in special cases, as needed.

**Scheduling conflicts can be avoided** – keep our office staff informed of any pre-existing obligations (doctor’s visits and other appointments) as far in advance as possible. Our staff is scheduling 10 – 14 days ahead. If your status changes following a doctor’s appointment, please call to alert our office of a discharge or hold status.

**Cancellations:** If it is necessary for you to cancel your scheduled appointment, please notify our office as early as possible (24 hour notice is appreciated); this allows us to make maximum use of professional time and schedule those patients who may be on a waiting list.

**No Shows:** No shows are appointments missed without notifying our office, or less than three hours notification of a cancelled appointment. No shows are not guaranteed their next scheduled time will be held. It is the patient’s responsibility to call and verify their current schedule.

**Billing:** Billing for Fyzical Therapy and Balance Centers of Sanibel is processed by our Wisconsin Business Office. Questions regarding your bill may be answered by that office at 262-376-9130. Third party payers are billed directly by that office. Patients are responsible for any deductible and/or services third party payers do not cover.

**Insurance:** Patients are responsible for knowing their own individual insurance coverage. If you change insurance during the course of therapy, you must advise us on your next visit or call our office at 239-395-1097.

**Patients must:**

1. Understand that we expect to have the patient/family support and involvement in the treatment program.
2. Be willing to provide accurate information about their medical condition.
3. Be willing and able to follow instructions during treatment.
4. Be willing to follow department policies and rules.
5. Be willing to treat department staff the way that you would want to be treated.

***I hereby acknowledge that I have read and understand the above policies.***

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FYZICAL THERAPY AND BALANCE CENTERS OF SANIBEL**

**4301 SANIBEL CAPTIVA ROAD**

**SANIBEL FL 33957**

**PHONE 239.395.1097 FAX 239.395.1968**

1. **PROFESSIONAL FEES**: Fees for professional services are based on our experience and not on payment schedules promoted by insurance companies as usual and customary. In many cases an insurance company will pay all the fees while in other cases only a portion of the fee. **We do not accept a lesser amount from an insurance company than Medicare pays for our services**. We will furnish a reasonable number of medical and insurance reports to expedite your insurance claims.

2. **FINANCIAL AGREEMENT**: I hereby authorize payment of medical insurance benefits due me (my dependent) to be made directly to Fyzical Therapy and Balance Centers of Sanibel. I understand that I am responsible for that portion of fees not paid by insurance. MasterCard and Visa are accepted. Should the amount be referred to an attorney or agency for collection, I will be responsible for reasonable attorney’s fees and collection expenses.

1. **CANCELLATION POLICY**: Fyzical Therapy and Balance Centers of Sanibel enforces a 24 hour cancellation policy. For each appointment missed without proper notice, a $25 fee will be charged. I will be responsible for the $25 fee charged for cancellation without proper notice.
2. **RELEASE OF INFORMATION**: I authorize Fyzical Therapy and Balance Centers of Sanibel to furnish insurance companies and/or their representatives, physicians, or other parties as indicated information concerning my (my dependent’s) illness, injury, and/or treatment necessary for completion of claims for insurance benefits.

**Please let us know how you found out about**

**Fyzical Therapy and Balance Centers of Sanibel.**

FORMER PATIENT YES NO DOCTOR REFERRAL YES NO

FRIEND YES NO FLYER YES NO

NEWSPAPER AD YES NO YELLOW PAGES YES NO

OTHER YES NO

Signature: Date: