Tallahassee Orthopedic & Sports Physical Therapy — Patient Information

Appointment Date:_____ Time:_____ PT:_____ NP/ONP Acct #:_____

Primary Care Physician: _____ Phone #: _____

Referring Physician:_____ Phone #:_____

Referral Date: Emp. Initials: Fin. Class: Next doctor appt:_____

Patient Name: First_____ MI _____ Last_____

Date of Birth:_____ **Social Security #:**_____ **Sex:**___ **Marital Status:**_____

Phone # Home:_____ **Cell:** _____ **Student:** Yes □ No □

Current Address:_____ **Apt. #:**_____

City: _____ **State:**_____ **Zip:** _____ **E-mail:**_____

Permanent Address: _____

City: _____ **State:**_____ **Zip:** _____ **Guarantor:** _____

Employer:_____ **Employer Phone:**_____

Emergency Contact: _____ **Relationship:** _____ **Phone #:**_____

Auto Related: Yes □ No □ If Yes: **Date of Accident:** _____ **State:** _____ **Ambulance Called:** Yes □ No □

Medical providers seen for this accident:1._____ **2.**_____

3. _____ **4.** _____ **5.** _____

Work Related -Yes □ No □ **Date of Accident/Injury:** _____ **Employer:** _____

Phone#:_____ **Surgery:** Yes □ No □ **Surgery Date:**_____ **Diagnosis:** _____

Primary Insurance: _____ Claims address: _____

Policy holder name:_____ _____

Policy holder DOB: _____ SS#:_____ _____

Policy #:_____ Group #: _____

Benefits: Eff. Date _____ Visit Limit: _____ Ded: $_____ Remaining: $_____

OOP: $ Remaining: $ Copay/Co-ins or other:

Second/Sup/ Insurance: _____ Claims address: _____

Policy holder name:_____ _____

Policy holder DOB: _____ SS#:_____ _____

Policy #:_____ Group #: _____

Benefits: Eff. Date _____ Visit Limit: _____ Ded: $_____ Remaining: $_____

OOP: $ Remaining: $ Copay/Co-ins or other: $

WC or Auto - Insurance:_____ Claim #: _____

Adj./NCM: _____ Phone#: _____

Auth #: _____ Visit Limit/Case Rate: _____ Fax #: _____

Attorney: _____ Phone # _____ LOP Yes □ No □

Auth. Verified by: _____ Date: _____

Tallahassee Orthopedic & Sports Physical Therapy

Insurance Benefits and Financial Agreement

Insurance benefits have been verbally explained to me, and the benefit coverage has been provided to TOSPT by my insurance company. Co-pays, co-insurance and deductibles are due at the time of service. All insurances will be verified and billed as a courtesy. I understand that it is my ultimate responsibility to understand my own insurance benefits. I understand that even if benefits are verified by your insurance company to TOSPT this not a guarantee of that those benefits are available and that I am ultimately responsible for payment. My insurance carrier: _____ states I have a $_____co-pay/co-insurance and that I have a $_____deductible. As of today, $_____ has been met. The limits on my insurance policy are_____ visits per year. I understand my benefits and financial obligations. This information was verified through:

_____ Phone # _____

Reference # _____ Name: _____

Online source (attached): _____

READ THIS SECTION THOROUGHLY

I understand that these figures are only estimates and may not be what my insurance pays and that I will pay TOSPT any difference between the estimate and the payment. I further understand that any disputes on coverage are between me and my insurance company. Denial of payment from my insurance carrier does not relieve me of my responsibility to pay. Any balance not paid by me or my insurance company within 90 days of the date of service will accrue interest at 1.5% per month until paid in full.

I understand that if my account is not paid in full within 120 days from the date of service that my account will be placed with a collections agency and this could negatively affect my credit. I agree to pay any collections fee associated with my account being referred to collections.

TOSPT is not a CHP provider _____ Initial

THIS POLICY AND MY RESPONSIBILITES HAVE BEEN EXPLAINED TO ME THOROUGHLY AND I UNDERSTAND IT.

Patient's Printed Name:_____ **Date:**_____

Patient's Signature: _____ TOSPT IC _____ kk 5/5/2019

Attendance Policy I understand that I am responsible for my appointed times and TOSPT requires 24-hour notice for cancellation and rescheduling appointments. A *$25.00* no show/cancellation fee will be charged for any appointments not attended that were not cancelled or rescheduled at least 24 hours in advance. Patients with 3 no shows or cancellations will be seen on a work in basis only.

Consent for Medical Treatment

I give authorization to TOSPT and/or its staff to evaluate and treat me during my participation of physical therapy.

_____ Initial

Consent for Medical Treatment of Minor Child

I hereby authorize TOSPT to administer treatment as they so deem necessary to my _____, (son/daughter)

Name of child:_____

Parent's signature:_____Date:_____

Assumption of Risk

I understand that although TOSPT and its staff take precautions to safeguard my health and safety, injuries can and do occur while participating in physical activity. I hereby relieve all liability occurring from the performance of the therapist's instruction.

_____ Initial

Health Insurance Portability and Accountability Act (HIPAA) Release

I have read and fully understand the Notice of Privacy Practices post in the reception area. I may request a copy of the Notice of Privacy Practices at any time and hereby give Tallahassee Orthopedic & Sports Physical Therapy permission to release my medical information for the purposes of billing and medical consultation.

_____ Initial

Release of Records Authorization

TOSPT is authorized to *provide* and *request* from my referring physician, other physician and/or my attorney and other individuals or *entities I may later designate with a specific Medical Records Release Form*, information regarding my diagnosis and medical condition for physical therapy while under treatment. Information to be disclosed may include nature of impairment, contributing factors, subjective symptoms, diagnosis, prognosis, x-rays, MRI's, and other information pertinent to my treatment. I understand that according to HIPAA, access fees may be incurred for which I will be held responsible.

_____ Initial

Insurance Release

I authorize my insurance company or the Social Security Administration to disclose information regarding my insurance or Medicare coverage, including but not limited to: Verification of benefits, effective dates and type of coverage. I also request payment of benefits to Tallahassee Orthopedic and Sports Physical Therapy for services they provide.

_____ Initial

Medicare Recipient Notification

As of January 1, 2019, Medicare has implemented a "cap" for therapy services. Medicare recipients are limited to a total of $2040 towards Physical & Speech Therapy and an additional $2040 for Occupational Therapy during the calendar year. To help TOSPT in obtaining the most accurate information as possible, it is my responsibility to inform TOSPT of any therapy services I have received within the calendar year. If services provided are determined to be non-covered services by Medicare, I will be responsible for all charges exceeding the "cap" amount.

I have received prior Physical, Occupational or Speech Therapy during this calendar year: ❑YES ❑NO

If yes: approximate visits:_____Where:_____

Are you currently receiving any form of home health: ❑YES ❑ NO

Amount remaining before reaching the $2040 cap. _____

Patient's Signature: _____ TOSPT IC _____

I understand and agree to all clauses outlined in the above documents pages 1-3

Patient History Form

Name: _____ **Date:** _____ **Gender: M F**
Leisure activities, including exercise routines: _____
Occupation: _____ **Are you working now? Yes No**
Age: _____ **Height:** _____ **Weight:** _____ **Marital Status:** _____
Do you use tobacco? Yes No Have you used tobacco in the past? Yes No Smoking / Smokeless
Have you had surgery for your condition? Yes No Date if yes: _____
Are you on a work restriction from your doctor? Yes No Date last employed unrestricted: _____
Do you have a pacemaker? Yes No Are you latex sensitive? Yes No Hand dominance: Right Left
ALLERGIES: List any you have: _____
Do you have any open wounds or incisions? Yes No Where? _____
FOR WOMEN: Are you currently pregnant or think you might be pregnant? Yes No

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Have you RECENTLY noted any of the following (check all that apply)?

- ❑ fatigue
- ❑ fever/chills/sweats
- ❑ nausea/vomiting
- ❑ fainting/loss of consciousness
- ❑ difficulty maintaining balance while walking
- ❑ change in mental status
- ❑ changes in menstrual cycle
- ❑ numbness or tingling
- ❑ muscle weakness
- ❑ dizziness/lightheadedness
- ❑ heartburn/indigestion
- ❑ difficulty swallowing
- ❑ changes in bowel or bladder function
- ❑ bowel or bladder incontinence
- ❑ constipation
- ❑ diarrhea
- ❑ shortness of breath
- ❑ falls
- ❑ cough
- ❑ headaches
- ❑ weight loss/gain

Have you EVER been diagnosed with or noted any of the following conditions (check all that apply)?

- ❑ cancer
- ❑ heart problems
- ❑ chest pain/angina
- ❑ high blood pressure
- ❑ circulation problems
- ❑ blood clots
- ❑ stroke
- ❑ anemia
- ❑ chemical dependency (i.e., alcoholism)
- ❑ Lyme disease
- ❑ irregular menstrual cycles
- ❑ eye problems/infections
- ❑ depression
- ❑ lung problems
- ❑ tuberculosis
- ❑ asthma
- ❑ rheumatoid arthritis
- ❑ other arthritic condition
- ❑ bladder/urinary tract infection
- ❑ eye irritation/infection
- ❑ sexually transmitted disease/HIV
- ❑ infection (skin, bone, joint, etc.)
- ❑ pelvic inflammatory disease
- ❑ immunosuppression (from steroids, transplants, etc.)
- ❑ thyroid problems
- ❑ diabetes
- ❑ osteoporosis
- ❑ multiple sclerosis
- ❑ epilepsy
- ❑ kidney problems
- ❑ ulcers
- ❑ liver problems
- ❑ hepatitis
- ❑ fractures
- ❑ hearing problems

❑ Other: _____

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ cancer
- ❑ heart problems
- ❑ high blood pressure
- ❑ diabetes
- ❑ stroke
- ❑ depression
- ❑ tuberculosis
- ❑ thyroid problems
- ❑ blood clots

❑ Other: _____

During the past month have you been feeling down, depressed or hopeless? **YES NO**
During the past month have you been bothered by having little interest or pleasure in doing things? **YES NO**
Is this something with which you would like help? **YES YES, BUT NOT TODAY NO**
Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? **YES NO**
Are you presently undergoing or have undergone psychological counseling? **YES NO**

Please list any medications you are currently taking (pills, injections, skin patches, supplements, etc.):
1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____
Have you ever taken steroid medications for any medical conditions? **YES NO**
Have you ever taken blood thinning or anticoagulant medications for any medical conditions? **YES NO**
Please list any surgeries you have had in the past, including dates:
1. _____ 2. _____ 3. _____
Please list any conditions for which you have been hospitalized, including dates:
1. _____ 2. _____ 3. _____
What date (roughly) did your present symptoms start? _____

What do you think caused your symptoms? _____

My symptoms are currently: ❑ **Getting Better** ❑ **Getting Worse** ❑ **Staying about the same**

I should not do physical activities that might make my pain worse: ❑ Disagree ❑ Unsure ❑ Agree

Treatment received so far for this problem (chiropractic, injections, etc) _____

Effect of treatment: _____

Have you had any of the following tests performed? (check all that apply) ❑ X-Rays ❑ MRI

❑ PET Scan ❑ CT Scan ❑ Bone Scan ❑ NCV/EMG ❑ Other _____

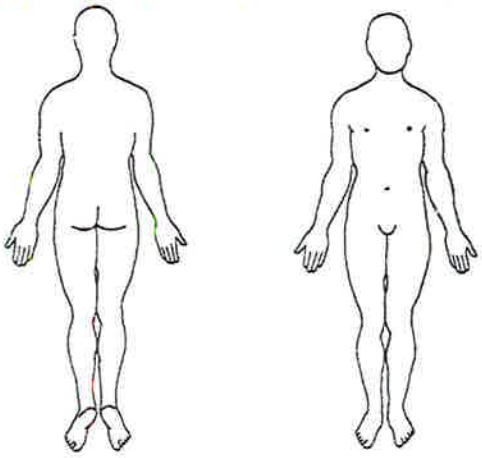
Have you ever had this problem before: ❑ **Yes** ❑ **No**

If Yes, When _____ **Treatment received** _____

If Yes, How long did it take for you to feel better? _____

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:



↓ **Shooting/sharp pain**
O **Dull/aching pain**
||| **Numbness**
= **Tingling**

For the therapist:
+/- Cough/Sneeze
+/- Saddle Anesthesia
+/- ~~Bowel/Bladder Changes~~
+/- Numbness/Tingling

My symptoms currently: ❑ Come and go ❑ Are Constant ❑ Increase with activity ❑ Decrease with activity

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Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:

1. _____
2. _____
3. _____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

1. _____
2. _____
3. _____

PSFS: Identify 3 activities that you are unable to do or having difficulty with as a result of your problem. For each activity please select a number on a scale of 0 – 10, where **0 indicates inability to perform activity, and 10 indicates ability perform activity at pre-injury level**

1. _____ 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
2. _____ 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
3. _____ 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

How are you currently able to sleep at night due to your symptoms?

❑ No problem sleeping ❑ Difficulty falling asleep ❑ Awakened by pain ❑ Sleep only with medication

When are your symptoms worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

When are your symptoms the best? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

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Using the 0 to 10 scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:

Current level of pain:	**Least** amount of pain in past 24 hours	**Most** amount of pain in past 24 hours
_____/10_	_____/10_	_____/10_

For the therapist: PSFS score: _____ Pain score: _____

Reviewed by: _____ Date: _____

Action needed: Yes No Patient referred out: Yes No Referred to: _____ Called physician Sent to ER

Tallahassee Orthopedic & Sports Physical Therapy

Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Tallahassee Orthopedic & Sports Physical Therapy (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.

2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.

3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: 1891 Capital Circle NE, Suite 2, Tallahassee, FL 32308, Attention: Compliance Officer

4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me except in very limited circumstances as described in the Privacy Notice, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

   I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions): _____

_____

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

_____ _____

Signature of Patient or Representative Date

_____

Patient's Name

_____

Date of Birth

_____

Social Security Number

_____ _____

Name of Personal Representative (if applicable) Relationship to Patient

To Be Completed by the Practice

The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:

_____ Accepted _____ Denied _____ Not Applicable

_____ Other (explain) _____

_____ _____

Signature of Authorized Practice Representative Date

Tallahassee Orthopedic & Sports Physical Therapy

Patient Authorization for Practice to Obtain or Release Protected Health Information

This Authorization for the use and/or disclosure of the specific personally identifiable health information set forth in this Authorization is made pursuant to the requirements of 45 CFR §164.508, which sets out the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 and authorizes Tallahassee Orthopedic & Sports Physical Therapy (the "Practice") to obtain, use and disclose the personally identifiable health information specifically referenced in this Authorization.

Please read the following information carefully:

I, the undersigned, authorize the use and/or disclosure of personally identifiable health information about me as described below:

1. I authorize the following person(s) or class of persons to use and/or disclose the information:
   _____
2. I authorize the following person(s) or class of persons to receive the information:
   _____
3. The following is a description of the information that I authorize to be used and/or disclosed:
   _____
   _____
4. The information will be used and/or disclosed only for the following purposes:
   _____
   _____
5. I understand and acknowledge that if the person or entity that receives the information is not a health care provider, health plan, or other entity covered by the federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.
6. I understand that the Practice will receive compensation for its use and/or disclosure of the information.
7. I understand and acknowledge that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I understand that I may inspect or copy any information used and/or disclosed under this Authorization.
8. I understand and acknowledge that I may revoke this Authorization at any time by sending a written revocation to the Practice at the following address3334 Capital Medical Blvd. Suite 300, Tallahassee, FL 32308 Attention: Compliance Officer. However, I also understand and acknowledge that if I revoke this Authorization, my revocation will not be effective to the extent that the Practice has already acted in reliance on this Authorization.
9. This Authorization expires _____ (insert applicable date or event).

I understand all of the provisions in this Authorization, and I wish to execute this Authorization thereby authorizing the use and/or disclosure of the information described above for the purposes described above.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED THIS AUTHORIZATION AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR THE PURPOSES SET FORTH WITHIN THIS AUTHORIZATION

_____ _____
Signature of Patient or Representative Date

_____
Patient's Name

_____
Date of Birth

_____
Social Security Number

_____ _____
Name of Personal Representative (if applicable) Relationship to Patient

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A copy of the completed and signed Authorization form has been provided to the patient or representative: _____Yes _____No

_____ _____
Signature of Authorized Practice Representative Date