PATIENT INFORMATION

Patient's Full Name: _____ Today's Date: _____

Date of Birth: _____ Gender (Please Circle): Male or Female Height: _____ Weight: _____

Mailing Address _____
(number and street) (city) (state) (zip)

Home # (_____) _____ Cellular # (_____) _____ Work # (_____) _____

Social Security # _____ Are you currently Working? Yes or No

Employer: _____ Occupation: _____

Email address: _____

Emergency Contact: _____ _____ Phone # (_____) _____
(Contact Name) (Relationship)

Referring Physician: _____ Referring Physician #: _____

Primary Care Physician _____ Primary Care Physician #: _____

Would you like us to provide appointment reminders? Y/N Can we leave a message regarding appointment times on your:

home phone Y/N work phone Y/N cell phone Y/N

► INSURANCE INFORMATION

Primary Insurance: _____ Policy # _____ Group #: _____

Secondary Insurance: _____ Policy # _____ Group #: _____

Is this patient the policy holder? (Please Circle) Yes or No If not, what is the Policy holder name: _____

Policy Holder Date of Birth: _____ Relationship to Patient: _____

► Workers Compensation Carrier ◄ _____ Claim # _____

► If Patient a minor please list Mother/Father/Guardian Information ◄

Name: _____ Relationship to Patient: _____ Phone Number: _____

Name: _____ Relationship to Patient: _____ Phone Number: _____

For patients under 18 years of age, the parent, relative, or person *escorting* the patient is responsible for any payments due at the time of the service.

- I understand that I am responsible for all charges incurred regardless of insurance or third party liability.
- I authorize contact by the use of my mobile/cell phone number for discussing treatment, confirming appointments and resolution of the balance of my account.
- I authorize Direct Physical Therapy to release any medical information necessary to process my claim to my insurance company or to any other concerned third party.
- I understand that I will bear the cost for all associated collections and/or attorney/legal fees if my account is placed with a 3rd party agency and/or attorney for collections or legal action.
- I authorize my insurance company or any other concerned third party to make payment directly to Direct Physical Therapy.

_____ _____

Signature **Date**

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DIRECT PHYSICAL THERAPY LLC -FINANCIAL POLICY

This is an agreement between Direct Physical Therapy and _____.
(please print name)

I understand that my insurance contract is between me, my employer (if applicable) and the insurance carrier and that Direct Physical Therapy, LLC., and/or its subsidiaries and affiliates, is not a party to that contract. I understand that, as a matter of process, Direct Physical Therapy, LLC will contact my insurance carrier (including Medicare) to verify my benefits and the services covered under my insurance contract. I acknowledge that providing ***accurate*** insurance information is critical to determining my eligibility under my insurance contract. I understand that Direct Physical Therapy, LLC is verifying benefits as a courtesy and that ultimately it is my responsibility to understand what is covered and required under my policy. By executing this agreement, you are agreeing to pay for all services that are received at time of service.

Monthly Statement:
If you have a balance on your account, our billing company ***Health Ledger Services*** will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance/rebilling charge, if any, and any payments or credits applied to your account during the month.

Payment options if you have NO insurance:

1. You may choose to pay by _____cash, ____check, or _____credit card at the time the services are rendered. Our cash payment option for patients without insurance is one hundred and twenty-five dollars ($125) for Initial Evaluation. Payment is expected at the time of service. Successive sessions will be one hundred dollar ($100) per visit (each session typically last for 60 to 75 minutes).

Payment options if you have insurance:

1. If you still have a deductible to meet, you will need to pay the contracted rate of your insurance provider and Direct Physical Therapy by ____cash, ____check, or ____credit card at the time services are rendered.

VERIFICATION OF BENEFITS: Your primary health insurance carrier had verified that you have a $ _____yearly deductible of which $_____ has been met. After your deductible has been satisfied, your insurance carrier estimates your therapeutic benefits are covered at _____%. You have an estimated responsibility of $ _____ or %_____due at each visit. Your insurance carrier has advised us that your policy has the following limitations:_____

ASSIGNMENT OF BENEFITS: I, the undersigned, hereby assign to Direct Physical Therapy, LLC (hereinafter "Assignee") any and all rights, claims, benefits, and causes of action for personal injury protection benefits and medical payment benefits available to me under the policy affording coverage to me for any and all treatment, services, and medical claims resulting from an automobile accident that occurred on _____. This is to act as an assignment of my rights and benefits to the extent of Assignee's services provided. In the event that I do not have insurance coverage, I understand that I remain personally responsible for payment of services rendered including all costs of collection, including attorney's fees and costs.

Consent to Release Medical Information: I authorize Direct Physical Therapy to release any information acquired in connection with my therapy services including, but not limited to, diagnosis, clinical records, to myself, my insurance(s), physician(s), and _____ consent to Obtain Medical Information: I authorize Direct Physical Therapy, LLC to obtain and acquire any information that would be beneficial

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connection with my therapy service, which may include X-rays, Cat scans, and MRI reports, along with Physician's Documentation.

Photo Release: Direct Physical Therapy has my permission to use my photograph publicly to promote DPT. I understand the images may be used in print publications, online publications, presentations, website and social Media. I also understand that no royalty, fee or other compensation shall be payable to me by reason of such use.

Returned Checks: There is a $30 fee for any checks returned by your bank.

Missed Appointments: I understand that if I need to cancel an appointment I will do my best to call **within 24 hours.** It is understood that 24 hours will not always be possible, however if there are consistent cancellations or failures to show for scheduled appointments, there will be a $25.00 fee that will be assessed to your account. ***We will notify you first***. We also reserve the right to discharge you from care and notify your physician for non-compliance. Your insurance company is not responsible for any appointments you are unable to make without proper notice.

Conduct: For your safety, the safety of Direct Physical Therapy employee's and the safety of our other patients we reserve the right to reschedule your therapy session for anyone that appears to be under the influence of alcohol or other substances. Inappropriate behavior or such as vulgar language, verbal abuse, aggressive behavior, Sexual harassment, including sexual comments and unwanted touching toward our staff will result in immediate termination of your therapy appointment and you will be referred to another provider.

Effective Date: Once you have signed this agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's name: _____ Signature: _____Date: _____

Responsible Party: _____(if not the patient)

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of protected health information (PHI). The individual is also provided the right to request confidential communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply)

□ **Home Telephone** _____
□ O.K. to leave message with detailed information
□ Leave message with call-back number only

□ **Cell Phone** _____
□ O.K. to text message with detailed information
□ Leave text message with call-back number only

□ **Work Telephone**_____
□ O.K. to leave message with detailed information
□ Leave message with call-back number only

□ **Written Communication**
□ O.K. to mail to my home address
□ O.K to mail to my work/office

Patient Signature _____Date _____

Printed Name_____ Date_____

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Release of Information to Family/Friends and Others

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to obtain authorization before releasing written or verbal information regarding any patient. Please fill out the form accordingly. We thank you for your help and understanding.

I, _____, authorize Direct Physical Therapy, LLC and its staff to release information regarding my condition to the following people:

1._____ 4._____

2._____ 5._____

3._____ 6._____

Patient Signature _____ Date _____

AUTHORIZATION CONSENT FOR CARE AND TREATMENT

I hereby give my consent to the facility and/or treating physicians and their agents to release all records, including via electronic transmittal, prepared in the course of my treatment, to any entity which provides financial assistance for my health care, including, but not limited to, insurance companies and their agents, self-insured employers or public welfare agencies. I certify that the information given by me in applying for payment under Title XVII of the social security act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or the Medicare program or its intermediaries or carriers, or to the professional standards review organizations any information needed for this or a related Medicare claim. I understand that by signing this form, records of a confidential nature, such as Social Security Numbers and those for HIV testing, AIDS or AIDS related condition, psychiatric problems or substance abuse, will be released to the entities providing financial assistance for my health care. This release includes disclosing data to local, state, federal, other entities for routine operational purpose of regulatory, legal or contract compliance, accreditation, peer review, quality improvement, continuity of care, or processing appeals for claims denials. I also understand that I may revoke this consent at any time and without revocation and that it will expire one year from this date, or if admitted, one year from the date of discharge. I acknowledge that I have been provided and given the opportunity to review the Facility's Information regarding patient's rights and responsibilities. I hereby authorize Direct Physical Therapy to provide care and treatment under my physician's direction or as allowed under my state's direct access provisions.

Signature of Patient or Guardian_____ DATE: _____

Name of Patient or Guardian: _____ DATE: _____

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NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient, and our common practices in dealing with patient health information.

Uses and Disclosure of Health Information:
We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization:
Except as stated in more detail in the Notice of Privacy Practice, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring your Authorization:
In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care
- For certain limited research purposes
- For purpose of health and safety
- To Government agencies for purposes of their audits, investigations, and oversight activities
- To Government authorities to prevent child abuse and domestic violence
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders
- When required by court orders, search warrants, subpoenas, and as otherwise required by law

Patient Rights:
As our patient, you have the following rights:

- To have access to and/or copies of your health information
- To receive an account or certain disclosures we have made of your health information
- To request restrictions as to how your health information is used or disclosed
- To request that we communicate with you in confidence.
- To request that we amend your health information
- To receive notice of our privacy practices

Please contact us with any questions, concerns, or complaints regarding our privacy practices.
I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understand the Notice.

Patient Name (please print): _____

Parent or Guardian: _____

Signature _____ **Date** _____

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PATIENT HISTORY FORM

What is the main reason or chief complaint for your Physical Therapy evaluation today (i.e. back pain):

_____

Date of Injury/accident: _____

If seen in E.R, which facility and Date: _____

Did you have any imaging done (X-ray, MRI, CT etc.) If yes, When _____

History of Present Problem

How did it happen: (i.e. lifted a box at work, two weeks ago)? _____

Have you had surgery for or to help this condition: _____ If yes, date of surgery: _____

Type of surgery: _____ Name of Surgeon: _____

Have you had a previous history of similar symptoms? _____ If yes, when was the last episode? _____

Did you receive Physical Therapy treatment for it? _____

If yes, where and how long? _____

Home Layout? 1 -story or 2-story What floor is your bedroom on? _____ -If second floor can temporary accommodations be made for the first floor? How many steps do you have to climb? _____

On a scale of 0-10 (0 is no pain, 10 is worst pain imaginable), circle the number that best describes your pain?

At Worse: 0 1 2 3 4 5 6 7 8 9 10

Current: 0 1 2 3 4 5 6 7 8 9 10

At Best: 0 1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?

days ago weeks ago months ago years ago
Other _____

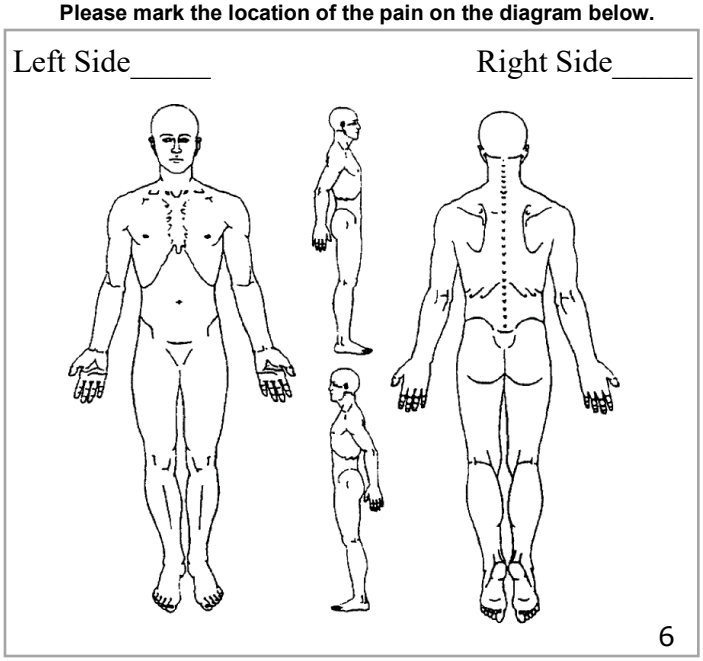
Problem **worsens** with:
Standing Lying Sitting Walking Stairs Up/Down
Voiding Coughing Sneezing Other _____

Problem **improves** with:
Movement Inactivity Standing Lying Sitting
Rest Medication Heat Ice Other _____

How frequently are you bothered by this problem?
Constant Occasional/Variable

How would you describe the problem/pain?
- Dull
- Burning
- Sharp
- Numbness
- Pounding
- Cramping/aching
- Deep
- Throbbing
- Intermittent
- Sharp and pin-point

Please mark the location of the pain on the diagram below.



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PAST MEDICAL HISTORY

Do you have a history of falls? Yes No

List any personal past illnesses &/or surgeries and when they occurred.

Illness or Surgery	Date	Illness or Surgery	Date
_____	_____	_____	_____
_____	_____	_____	_____

List all serious illnesses in your **family**. (Example: Diabetes, Tuberculosis, Breast Cancer, Heart disease, etc.)

_____
_____
_____

List all current prescription medications?	Dose	Frequency	Route/administration
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	

Any over the counter medications? No Yes Please explain: _____

Do you have allergies? No Yes Please explain: _____

Do you smoke? No Yes How much?: _____ Do you drink? No Yes How much? _____

What is/was your occupation? _____ Employer Name: _____

1. Do you have any other conditions that may limit your response to exercise? Y____ N _____
2. Do you lose your balance because of dizziness or do you ever lose consciousness? Y ____ N _____
3. Do you have any other bone or joint problems (i.e. back, knee or hip) Y _____ N _____
   If yes, Please explain: _____
4. What are your hobbies/recreational activities? _____
5. Have you had any recent illnesses within the past 2-3 weeks? (i.e. Colds, flu, bladder/kidney infection.) Y___ N ___
   If yes, Please explain: _____
6. Have you noticed any lumps or thickening of skin or muscle anywhere in your body? Y___ N ___
   If yes, Please explain: _____
7. Do you have any sores/infections which haven't healed or any changes in size, shape or color of wart or mole? Y___ N ___
8. Do you have any special needs and or considerations? Y___ N ___
   If yes, Please explain: _____
9. Have you had any unexplained weight loss or gain in the last month? Y___ N ___
   If yes, Please explain: _____
10. Is there a possibility that you may be pregnant? Y___ N ___
11. Do you need assistance with any medical equipment? (walker, shower chair, cane etc.) Y_____ N_____.

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MEDICAL HISTORY

Cardiovascular		
Heart problems	Y	N
Stroke	Y	N
Pacemaker	Y	N
High blood pressure	Y	N
Cancer	Y	N
Lung Problem	Y	N

Musculoskeletal		
Cauda Equina Syndrome	Y	N
Joint Pain	Y	N
Joint replacement/implants	Y	N
Osteoporosis	Y	N
Frequent/easy Bleeding	Y	N
Frequent/easy Bruising	Y	N

Constitutional Symptoms		
Current Infection	Y	N
Fever	Y	N
Chills	Y	N
Frequent Headache	Y	N
Weightloss	Y	N
Sleeping Disorder	Y	N

Endocrine		
Diabetes Type 1	Y	N
Diabetes Type 2	Y	N
Tired/Sluggish	Y	N
Excessive thirst	Y	N
Frequent Urination	Y	N
Hypothyroidism	Y	N
Cushing's syndrome	Y	N
Addison's Disease	Y	N

Immunologic/ Allergic		
Fibromyalgia	Y	N
Lupus	Y	N
Rheumatoid Arthritis	Y	N
Osteoarthritis	Y	N
Huntington's	Y	N
Immunosuppression	Y	N
HIV/AIDS	Y	N

Eyes		
Blurred Vision	Y	N
Double Vision	Y	N
Hay Fever	Y	N

Neurological		
Alzheimer's disease	Y	N
Dizzy Spells	Y	N
Numbness/tingling	Y	N
Epilepsy	Y	N
Parkinson's Disease	Y	N
Multiple Sclerosis	Y	N
Seizures	Y	N
Memory Issues	Y	N

Gastrointestinal		
Abdominal pain	Y	N
Nausea/vomiting	Y	N
NSAIDS	Y	N
Anticoagulantes	Y	N
Oral corticosteroides	Y	N
Antidepressants	Y	N

Hematologic/Lymphatic		
Numbness or tingling in Hands or Feet	Y	N
History of Injection Drug Use	Y	N
Alcohol Use	Y	N
Prescribed Statins	Y	N

Ear/Nose/Throat/Mouth		
Ear Infection	Y	N
Sore Throat	Y	N
Sinus Problems	Y	N
Asthma	Y	N

Genitourinary		
Urine Retention	Y	N
Painful Urination	Y	N
Urinate Frequently	Y	N

Pulmonary		
Wheezing	Y	N
Shortness of Breath	Y	N
Pneumonia	Y	N

OVER THE PAST TWO WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS?	*NOT AT ALL*	*SEVERAL DAYS*	*MORE THAN ONE-HALF THE DAYS*	*NEARLY EVERY DAY*
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

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MEDICARE PATIENT'S ONLY

1. Has someone other than your family assisted you in your home with services in the past 30 days?

   Yes _____ No_____

2. Have you received any Home Therapy in the last 3 months? Yes _____ No_____

   Name of Home Health Agency:_____Date Last Seen:_____

3. Have you received ANY therapy in or out of the state of Florida? Yes _____ No____

   Name of Therapy Provider: _____

   Date Seen: _____ Was therapy for the same issue: _____

   If no what was the issue you were seen for? _____

If you answered "YES" to any of the questions above, you may not be eligible for outpatient therapy services as determined by Medicare's guideline because if you are currently receiving Home Health Care (whether it is in home therapy or nursing), Medicare WILL NOT cover your outpatient therapy here at Direct Physical Therapy. You will need to be discharged completely from all homecare services.

MEDICARE CONDITIONS OF ADMISSION

Medicare has implemented the "Therapy Cap." This cap states that Medicare will only allow a specific amount of coverage a year for 2019 for outpatient Physical and Speech language pathology services combined. There are exemptions for certain diagnoses and our office can get approval allowing additional visits over the therapy cap. Exemptions do not apply in all cases and are based on the patient's diagnosis provided by the physician. We will do our best to respect the monetary cap, however we provide service based on patient need not insurance limitations. It is ultimately your responsibility to ensure that services being rendered are covered. If services are not covered or exceed the monetary therapy cap, then financial responsibility lies with you, the patient.

I authorize the payment of medical benefits directly to Direct Physical Therapy for services rendered. I understand that I am financially responsible for charges not covered by this authorization, except where prohibited by law.

Printed Name_____ Date _____

Patient's Signature_____

How did you hear about Direct Physical Therapy? Please check all that apply.

Doctor recommendation	_____	Location	_____
Friend/Family	_____	Facebook	_____
Saw sign	_____	Event	_____
Internet search	_____	Other	_____

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Direct Physical Therapy
1495 S. Volusia Ave Ste 101
Orange City, FL 32763
(386) 401-6100 Phone
(386) 960-0551 Fax

Physician_____

Address_____ City_____State_____ Zip_____

Phone_____ Fax_____

Thank you for allowing us to participate in your patients care.

- Patient's Medical History
- New Referral for Physical Therapy
- X-ray or MRI Reports
- _____

I authorize the release of and correspondence regarding my (or my dependent's) medical records to Direct Physical Therapy, LLC.

Date: _____ Date of Birth: _____

Patient Name _____

Signature _____ **Date** _____