PATIENTS HEALTH HISTORY – CURRENT INJURY/ILLNESS

Name:_____ Today's Date: _____

Address:_____

City_____ State _____ Zip Code_____

Phone: (Cell)_____ (Home)_____ (Work)_____

Age:_____ Date of Birth:_____ Sex:_____ Height: _____Ft._____In. Weight:_____lbs

Occupation:_____ R-Handed ☐ L-Handed ☐

Have you ever been a patient here before? Yes ☐ No ☐ If yes for the same ☐ or different ☐ problem?

Please indicate which body region you are seeking treatment for.

Neck ☐ Mid Back ☐ Low Back ☐ Shoulder ☐ Elbow ☐ Hand/Wrist ☐ Hip ☐ Knee ☐ Ankle/foot ☐ Other ☐

When did your symptoms start? Date:_____ Can you identify the cause for your symptoms? Yes ☐ No ☐

If yes, please specify:_____

Have you recently had the following tests? Check all that apply.

☐ x-rays ☐ Bone Scan ☐ Myelogram ☐ EKG ☐ CT Scan ☐ EMG ☐ Stress Test ☐ Echocardiogram

☐ MRI ☐ Blood Tests ☐ Pulmonary function test ☐ Other: please list _____

Pain rating: Indicate your average level of pain by check the appropriate number on the scale below.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

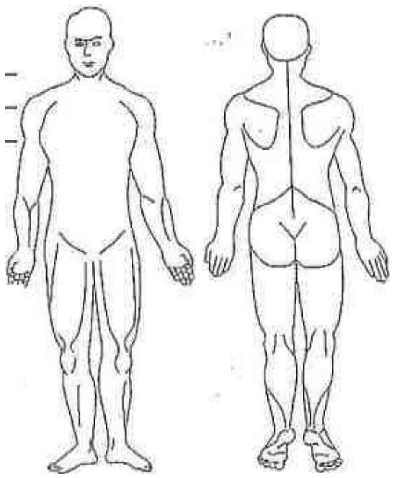
Pain Free *Unconcsious*

Describe the character of your pain. (Sharp, dull, achy, etc.)

_____

_____

_____



Mark areas of pain on the diagram

Is the pain there all the time (constant)? Yes ☐ No ☐

Does the pain move or radiate anywhere? Yes ☐ No ☐

If yes, describe location of radiation:_____

Do you have numbness, tingling, or weakness? Yes ☐ No ☐

If Yes, please describe:_____

Have you had any changes in your bowel, bladder, or sexual function as a result of your symptoms? Yes ☐ No ☐

If yes, please describe:_____

What activities make your pain worse? _____

_____

_____

What activities make your pain better? _____

_____

_____

Existing or Relevant previous conditions: Check all that apply.

Cancer		Yes		No	Diabetes		Yes		No	Metal Implants		Yes		No
Cardiac Conditions		Yes		No	Dizzy		Yes		No	MRSA		Yes		No
Cardiac Pacemaker		Yes		No	Emphysema/Bronchitis		Yes		No	Multiple Sclerosis		Yes		No
Currently Pregnant		Yes		No	Fibromyalgia		Yes		No	Muscular Disease		Yes		No
Defibrillator		Yes		No	Fractures		Yes		No	Osteoporosis		Yes		No
Allergies		Yes		No	Gallbladder Problems		Yes		No	Parkinson's		Yes		No
Anemia		Yes		No	Headaches		Yes		No	Rheumatoid Arthritis		Yes		No
Anxiety		Yes		No	Hearing impairment		Yes		No	Seizures		Yes		No
Arthritis		Yes		No	Hepatitis		Yes		No	Smoking		Yes		No
Asthma		Yes		No	High/Low Blood pressure		Yes		No	Speech Problems		Yes		No
Autoimmune Disorder		Yes		No	High Cholesterol		Yes		No	Strokes		Yes		No
Chemical Dependency		Yes		No	HIV/AIDS		Yes		No	Thyroid Disease		Yes		No
Circulation Problems		Yes		No	Incontinence		Yes		No	Tuberculosis		Yes		No
Depression		Yes		No	Kidney Problems		Yes		No	Vision Problems		Yes		No

Describe any other conditions: _____

If yes to any of the above, please explain and give approximate dates.

Fall History:

☐ Injury as a result of fall in the past year

☐ Two or more falls in the last year

Surgical History *(list surgeries related to the current condition/issue)*

Body Region:_____Surgery Type:_____Date:_____

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Body Region:_____Surgery Type:_____Date:_____

Current Medications: If providing a separate list, Initial here and provide a copy to therapist at evaluation. _____(*patient initials)*

Drug:_____ Dosage:_____ Frequency:_____ Indicated for:_____

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Drug:_____ Dosage:_____ Frequency:_____ Indicated for:_____

Drug:_____ Dosage:_____ Frequency:_____ Indicated for:_____

Drug:_____ Dosage:_____ Frequency:_____ Indicated for:_____

Currently not taking any medications ☐

Have you previously seen any other health care provider for this problem? Check all that apply

☐ Physician ☐ Osteopath ☐ Podiatrist ☐ Physical Therapist ☐ Chiropractor ☐ Dentist ☐ Other:_____

Are you currently seeing any other health provider for this condition? ☐ Yes ☐ No

Have you been discharged from a hospital, skilled nursing facility, or home health agency in the past 30 days related to this condition?

☐ Yes ☐ No If Yes, Please describe:_____

Please check the treatments listed below that you have tried in the past.

☐ Physical Therapy ☐ Chiropractic ☐ Acupuncture ☐ Braces ☐ Collars ☐ Tens Unit ☐ Injections

☐ Medications ☐ None ☐ Other:_____

Have you had an allergic reaction to: ☐ Lotion ☐ Perfume ☐ Gel ☐ Latex ☐ Adhesives

Which over-the-counter medications have you taken in the last week?

☐ Aspirin ☐ Tylenol ☐ Advil/Motrin/Ibuprofen ☐ Decongestants ☐ Laxatives ☐ Antacid

☐ Antihistamines ☐ Vitamins/Supplements:_____

Have you recently noted:

	Yes		No	Weight Loss/ Gain		Yes		No	Nausea / Vomiting
	Yes		No	Dizziness /Lightheadedness		Yes		No	Fatigue
	Yes		No	Fever / Chills / Sweats		Yes		NO	Body Aches

Do you have a Pacemaker? ☐ Yes ☐ No

Job Description / Social Activities: *(Physical tasks, amount of sitting, lifting, computer work etc.)*

_____

_____

_____

_____

What are your goals for the course of physical therapy?

_____

_____

_____

_____

_____ _____

Patient Signature **Date**

_____ _____

Evaluating Physical Therapist Print **License Number**

_____ _____

Evaluating Physical Therapist Signature **Date**

ASSIGNMENT OF MEDICAL BENEFITS, PAYMENT RESPONSIBILITY AND CONSENT FOR TREATMENT

Patient:_____

1. THE UNDERSIGNED, hereby authorized Apex Physical Therapy/Concepts in Rehab, Inc., and its affiliates (*Provider*) to render to Patient physical therapy that Provider or Patient's treating physician determines may be necessary or advisable. Patient agrees to cooperate with all reasonable requests by Providers in connection with Provider's rendition of Therapy Services.
2. THE UNDERSIGNED, hereby certify that all information provided to Provider by the undersigned or Patient, including any information in connection with applying for a payment under Title XVII of the Social Security Act, is true and accurate in all respects.
3. THE UNDERSIGNED, hereby authorize Provider to disclose any information, furnished to Provider or obtained by the Provider in connection with Patient's treatment (including the Social Security Administration or any of its intermediaries or carries), insurance company or health care facility requesting such information
4. THE UNDERSIGNED, hereby assign to Provider all Medicare benefits which Patient may be entitled for any Therapy Services rendered by Provider. The undersigned hereby authorize and direct Provider to apply and file for all such benefits on behalf of Patient. In addition, the undersigned approves contact with the appropriate family members for medical claims management purposes.
5. THE UNDERSIGNED, hereby assign to Provider all private medical insurance benefits (primary and secondary, including med. Gap provider) or other benefits to which Patient may be entitled for any Therapy Services rendered by Provider. The undersigned hereby authorize and direct provider to apply and file for all such benefits on behalf of the Patient.
6. THE UNDERSIGNED, authorizes Apex Physical Therapy/Concepts in Rehab, Inc. to deposit checks received on Patient's account when made out to the patient or signed over by the patient when Insurance Company pays against services provided.
7. THE UNDERSIGNED, agree that the undersigned shall be jointly and severally financially responsible for any portion of Provider's invoice that is not paid, except in the event of Medicare denial. The undersigned shall be liable to Provider for all services rendered by Provider in the event Patient is not covered by a health insurance plan.
8. THE UNDERSIGNED, and patient agree to execute any documents and perform any acts that Provider may reasonably request. The undersigned warrant and represent that attached hereto are originals or certified copies of any applicable powers of attorney, health care surrogate forms or court orders appointing the undersigned as the legal guardian of Patient.
9. THE UNDERSIGNED, agree that the provisions hereof shall continue in full force and effect until Provider has received written notice of termination signed by the undersigned; provided, however, that the provision of paragraphs 2, 4, 5, and 6 shall survive any such termination.
10. THE UNDERSIGNED, acknowledge that Provider has disclosed to the undersigned that no physician owns any interest to Provider.
11. THE UNDERSIGNED, understand that they have a choice of rehabilitation service providers.
12. THE UNDERSIGNED, authorize Apex Physical Therapy/Concepts in Rehab, Inc. to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Patient:_____ Date: _____

DIAGNOTIC TESTING SCREENING TOOL

Patient Name: _____ Date: _____

Dear Patient:

If you currently feel or have felt any of the following symptoms within the past month or if you have been diagnosed with any of the following conditions, please check the appropriate boxes. This is a screening tool that can help your therapist determine what diagnostic tests* or physical therapy might be appropriate for you.

PLEASE CHECK ALL THAT APPLY

	Low back and radiating pain		Neck pain and radiating pain
	Numbness, tingling, or burning sensation in the legs or feet.		Numbness, tingling or burning sensation in the arms or hands.
	Weakness in the legs or arms		Loss of sensation in hands/feet
	Diabetes or Neuropathy		Daily alcohol 3 glasses or more
	Thyroid Dysfunction		Muscle disease/ muscle cramping
	Tendinitis / Bursitis / Arthritis		Shoulder pain or instability
	Elbow pain or instability		Wrist-hand pain or instability
	Hip or knee pain or instability		Ankle-foot pain or instability
	Blurred vision		Hearing Problems
	Dizziness or vertigo		Headaches
	Unsteady Gait		History of falls due to dizziness
	Hypertension		Hypotension
	Anything else you consider important:		

_____ _____

Patient Signature Date

Assessment- _____

_____

Patient would benefit from PT
Patient would benefit from Diagnostics EMG / MSKUS

_____

Signature

*Electromyography/Nerve Conduction Studies, Autonomic System Testing, Somatosensory Evoked Potentials, Auditory & Visual Evoked Potentials, Musculoskeletal Ultrasound, Vestibular Testing.

CREDIT CARD AUTHORIZATION FORM

Patient Name:_____

Card Holder Name:_____

Card Type:_____ Card Number:_____

Expiration Date:_____ CVV:_____ Zip Code:_____

I, _____ give permission for Mac Consulting Plus, DBA Apex Physical Therapy, to automatically charge the aforementioned credit card for Physical Therapy, Athletic Performance and other services not covered by my insurance.

I understand it is my responsibility to notify Apex of any changes to the credit card information on file for the purpose of maintaining timely payments. I understand that if my credit card is declined for a regularly scheduled payment, an additional attempt will be made to collect the charges on the next business day. If those charges are again declined, my account may then be placed in collection status.

I understand I

_____ _____

Client Signature Date

FINANCIAL POLICY

We are committed to providing you with the best Therapy care. In order to do this without compromising our patients; this policy has been implemented for each patient. If you have medical Insurance, we are anxious to assist you in receiving your maximum allowable benefits. In order to achieve these goals, we need your assistance an understanding of our payment policy.

Payment for services is due at the time services are rendered, unless other acceptable and agreed-upon arrangements have been approved in advance by our Staff. We accept cash, checks, Visa, MasterCard, Discover and AmEx. We will be accommodating to you in the process of seeking reimbursement from your Insurance Carrier (in special circumstances, we may accept the assignment of insurance benefits.)

Deductibles, co-Insurance, and/or Co-Payments must be made at each visit. It is our policy to collect a percentage of each visit or the entire fee until a deductible has been reached.

Please be further advised that returned checks are subject to a $15

fee. Realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered by each carrier.
3. Not all services and diagnosis codes are a covered benefit in all insurance contracts.
4. We will not comprise patient care based on an insurance company's "Fee Schedule"
5. Verification of your insurance benefits is not a guarantee that payment will be made.

We must emphasize that as a Medical Provider, our relationship is with you, not your insurance company. While the filing of an insurance claim is a courtesy that we extend to our patients, all charges are your responsibility from the date the services were rendered. We realize that temporary financial problems may affect the timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

SELF PAY PATIENTS

Payment for services is due at the time services are rendered, unless other acceptable and agreed-upon arrangements have been approved in advance by our Staff. We require all self-pay patients to have a credit card on file during their time of treatment. Upon completion of your program, your card will be deleted from your file once all charges have been processed. **Purchase of all self-pay packages are nonrefundable** but can be applied to future visits.

If you have any questions about the above policy or any uncertainty regarding your insurance coverage, PLEASE do not hesitate to ask us for assistance, we would be HAPPY TO HELP YOU

Patient:_____ Date:_____

NOTICE OF PATIENT PRIVACY RIGHTS

This notice describes how medical and personal information about you may be used or disclosed and how you can obtain access to this information. Review this form carefully.

Our Legal Duty

Apex Physical Therapy/Concepts in Rehab, Inc. uses your personal and health information for treatment, obtaining payment for treatment, and for our health care operations. We are required by law to notify you in case of a breach of your unsecured protected health information when it has been or is reasonably believed to have been accessed, acquired or disclosed as a result of a breach. We are permitted to use PHI without written authorization in certain situations. We are able to disclose your health information for use in obtaining payment for services provided, for health care fraud and abuse, to a family member, relative, or friend involved in your care with your verbal agreement, to public health authorities in enforcement activities, for military and special government functions, to avert serious threats to the health and safety of a person, for worker's compensation purposes, to coroners, medical examiners and funeral directs, and to organ donor organizations. Any other use or disclosure of PHI will only be made with written authorization. Authorization may be revoked at any time, in writing, except to the extent that we have already used or disclosed medical information.

Your Individual Rights

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct inaccurate or incomplete information in your records. You also the right to request a list of instances where we disclosed your personal health information for reasons other than for treatment, payment , or other related administrative purposes. You may request in writing that we may not use or disclose your personal health information for treatment, payment or administrative purposes except when specifically authorized by you, when required by law, or in an emergency. You have the right to restrict disclosure of your personal health information to a health plan for payment if you have pain in full for the services provided.

Consent

With this consent, Apex Physical Therapy/Concepts in Rehab, Inc. may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPS, such as appointment reminders, insurance items and any calls pertaining to my critical care, including laboratory results, among others.

With this consent, Apex Physical Therapy/Concepts in Rehab, Inc. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements

Concerns and Complaints

If you are concerned that Apex Physical Therapy/Concepts in Rehab, Inc. may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our HIPAA Compliance Officer, Angela McGilvrey, at the office address and phone number listed below. You may send a written complaint to the US Department of Health and Human Services

Apex Physical Therapy/Concepts in Rehab, Inc.

HIPAA Compliance

Attn: Angela McGilvrey

15751 San Carlos Blvd Ste.
4 Fort Myers, Florida 33908
239.337.2739

Patient:_____ Date:._____

Witness:_____

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

I,_____hereby authorize Apex Physical Therapy/Concepts in Rehab, Inc., to obtain my Protected Health Information, including, but not limited to, History and physical exam, lab reports, progress notes and X- Ray reports.

I understand that this authorization will expire 365 days from the date I have signed this form, and that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified, except to the extent action has already been taken in reliance upon it. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations.

PRIVACY NOTICE

By my signature below, I acknowledge that I have received a copy of this practice's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under Federal and State law, and understand my rights as a patient regarding my personal health information.

Insured/Patient:_____Date_____

TREATMENT COMMITMENT

Apex Physical Therapy/Concepts in Rehab, Inc. CARE VERY MUCH ABOUT EACH PERSON WE TREAT. We are committing to you, our patient, to deliver *Exceptional Care,* with *Exceptional Results!* We request of you, our patient, a commitment to help us deliver what we promise, by understanding what is required of you. You play a large role in your health by the actions you chose to take. Listed are some of your responsibilities as a patient at Apex Physical Therapy/Concepts in Rehab, Inc.:

1. Attending, on time, all scheduled appointments
2. Informing your therapist of your progress, each visit.
3. Compliance with your treatment plan developed by the Therapist.
4. Notifying your therapist, in advance, of your next doctor's appointment.

PATIENT MISSED APPOINTMENT POLICY

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well- being and gain of your abilities is something everyone in our clinic takes very seriously. Your adherence to the recommended number of treatments is a vital component of your progress with our services/therefore we have certain rules that need to be followed to ensure the most optimum result.

In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care, and will inform your physician of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you!

By signing below, Patient agrees to and understands all items outlined above:

Insured/Patient:_____Date_____

IMAGE RELEASE

I understand that, from time to time, pictures or videos may be taken of the work that is going on a Apex Physical Therapy and/or Athletic Performance and shared for marketing or educational purposes. I hereby grand Apex Physical Therapy and Athletic Performance permission to use my likeness in video or photograph for its printed and digital publications, including social media platforms. I hereby release and hold harmless Apex Physical Therapy and Athletic performance from all claims, demands, and causes of action, which I, or anyone acting on my behalf, may have. In addition, I waive the right to inspect or approve the finished product and waive the right to any compensation arising out of the use of my likeness in any videos or photographs.

Signed:_____ Date:_____

I Hereby do not consent to Image Release

Signed: _____ Date: _____