

**Florida Sports Orthopaedic and Spine Medicine
Therapy Unit**

3890 Tampa Road #205

Palm Harbor, FL 34684

Patient Information Form

Today's Date: _____

Patient: _____

Last

First

Middle

If Patient is a minor, Parent's Name(s): _____

Date of Birth: _____

Age: _____

Sex: M F

Patient's SS#: _____

Marital Status: S M D W SEP

Address: _____

City

St

Zip

Home Ph: _____ Cell Ph: _____

Email address: _____ (will not be given to a third party)

Employer: _____ Work Ph: _____

What school do you attend (minor): _____ What sports do you play? _____

Primary Care Physician: _____ Phone: _____

Date of Injury/Onset: _____ Chief Complaint/Problem Area: _____

Insurance Information

Primary Insurance: _____ ID# _____

Insured Name _____ DOB: _____

Secondary Insurance: _____ ID# _____

Insured Name _____ DOB: _____

Is this a Worker's Compensation Injury? Yes No If YES, date of injury: _____

Is this related to an automobile accident? Yes No If YES, date of injury: _____

Is this related to a slip/fall accident? Yes No If YES, date of injury: _____

Are you currently involved in or do you plan litigation for this injury? Yes No If YES, Date: _____

If YES, Attorney Name: _____ Phone: _____

Are you currently involved in any other litigation? _____

May appointment reminders be left on your answering machine or voice mail? YES NO

Please list the name of the primary contact in case of emergency regarding your medical condition:

Name: _____ Relationship: _____ Phone: _____

HAVE YOU PREVIOUSLY RECEIVED THERAPY / SPEECH THERAPY IN THE LAST YEAR? IF YES, WHERE?

I certify that the information I have given on the Florida Sports and Ortho Med Therapy Unit forms is correct to the best of my knowledge and I will notify the office of any changes:

Signature of Patient: _____ Date: _____

Florida Sports Orthopaedic and Spine Medicine Authorization for Treatment and Payment Responsibility

1. The UNDERSIGNED hereby authorizes Florida Sports Orthopaedic and Spine Medicine (“Provider”) to render therapy treatment to patient. Patient agrees to cooperate with all reasonable requests by Provider in connection with Provider’s rendition of services.
2. The UNDERSIGNED certifies that all information provided to Provider by the undersigned or patient, including any information in connection with applying for payment under title XVIII of the Social Security Act, is true and accurate in all respects.
3. The UNDERSIGNED hereby authorizes Provided to disclose any information furnished to Provider or obtained by Provider in connection with the patient’s treatment (including information concerning a related Medicare claim), to any company, or healthcare facility requesting such information.
4. The UNDRESIGNED hereby authorizes Provider all Medicare benefits to which patient may be entitled for any services rendered by Provider. In addition, the undersigned appropriates family members for medical claims management purposes.
5. The UNDERSIGNED hereby assigns to Provider all Medicare insurance benefits (primary and secondary, including med gap providers) or other benefits to which patient may entitled for any services rendered by Provider. The undersigned hereby authorizes and directs Provider to apply and file all such benefit on behalf of patient.
6. The UNDRSIGNED agrees that the undersigned shall be ultimately financially responsible for any portion of Provider’s claim that is not paid. The undersigned understands that Medicare or any health maintenance organization (HMO) may deny some charges that the physician deems necessary. The undersigned agrees to be responsible for payment of these charges should they be denied for payment.
7. The UNDERSIGNED and patient agree to execute ay documents and perform any acts that Provider may reasonably request. The undersigned warrant and represent that any 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.
8. The UNDERSIGNED agrees that provisions hereof shall continue in full force and effect until Provider has received written notice of termination signed by the undersigned, however, the above mentioned paragraphs 2, 4, 5, and 6 shall survive any such termination.
9. The UNDERSIGNED grants permission for the Provider to treat the undersigned, and/or minor child and/or dependent. If minor, parent and/or guardian does not have to be present.
10. The UNDERSIGNED agrees that treatment by the Provider will not be constructed as willingness on the part of the Provider to be a witness in a persona; injury litigation case.
11. The UNDERSIGNED understands that confabulation or fabrication either by commission or omission will be sufficient reason for unilateral discontinuation of treatment and cancellation of any contract either expressed or implied.
12. The UNDERSIGNED understands and agrees the facility is not responsible for personal valuables or belongings brought into the clinic, or claimed to have been brought into the clinic.
13. PATIENT’S BILL OF RIGHTS AND RESPONSIBILITIES NOTICE OF PRIVACY: By my signature on this document, I acknowledge the availability and may request a copy of the Patient’s Bill of Rights and responsibilities brochure pursuant to Florida Statute 381.026 and the Notice of Privacy Practices prior to or anytime during my visit.

I CERTIFY THAT THE INFORMATION CONTAINED IN THE DOCUMENT HAS BEEN READ BY OR EXPLAINED TO ME AND I UNDERSTAND THIS INFORMATION. I WILL RECEVIE A COPY OF THIS DOCUMENT UPON REQUEST. I ACKNOWLEDGE THAT A COPY OF THIS DOCUMENT SHALL BE EFFECTIVE AS THE ORGINAL.

Patient/Parent Signature

Date

Signature of Patient’s Authorized Representative (other than parent)

MEDICAL HISTORY/BODY/PAIN CHART AND ADL SCREEN

How did this injury /exacerbation occur? _____ Date of onset? _____

Have you been hospitalized for the present condition? Yes No If yes, date: _____

Have you had surgery for the present condition? Yes No If yes, date: _____

Have you received previous treatment for this condition? Yes No If yes, date: _____

If yes, please summarize: _____

Are you currently receiving or have you received in the last 30 days any other home health, medical, or chiropractic services render to you by any other agency, organization, or individual? If yes, please summarize:

Are you on any medications? Please list (you may use the reverse side)

Have you had any of the following for this condition? XRAY MRI CAT SCAN EMG MYELOGRAM

Have you ever, or are you presently being

Treated for any of the following conditions?

Diabetes	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Headaches	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Dizzy Spells	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Fainting Spells	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Epilepsy	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Seizures	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Heart Trouble	<input type="checkbox"/> YES	<input type="checkbox"/> NO
High Blood Pressure	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Pacemaker	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Stroke/TIA	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Bleeding Disorder	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Asthma	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Emphysema	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Respiratory Problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Tuberculosis	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Osteoporosis	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Fracture	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Arthritis	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Hepatitis A, B, C	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Parkinson's Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Pregnancy	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Depression	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Fibromyalgia	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Cancer	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Allergies/Sensitivities:		
Other:		

PLEASE CIRCLE ALL THAT MAY APPLY

My pain is worse :

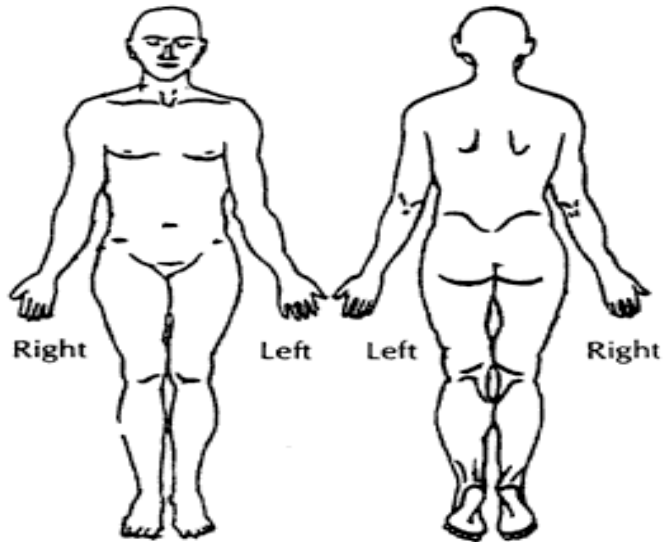
In the morning/during the day/at night/constant/with activity/during rest

On a scale of 0 to 10

(0 being no pain and 10 being unbearable pain requiring hospitalization)

Please rate your pain at its best _____ and at its worse _____

Using the key provided, please draw the symbol representing your pain over the area of the body as it relates to your present condition.



↑ or ↓ Radiating Pain XXX Spasm ZZZ Tenderness
 ///// Numbness-Tingling 0000 Ache/Pain

As it relates to your current problem, are you unable to or have difficulty with performing any of the following activities? Do you have pain associated with or have you changed your method of performing any of the following tasks? Check all that apply.

- | | | | | |
|---|--|-----------------------------------|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Getting in/out of bed | <input type="checkbox"/> Personal hygiene activities | <input type="checkbox"/> Eating | <input type="checkbox"/> Shaving | <input type="checkbox"/> Cleaning |
| <input type="checkbox"/> Getting in/out of a car | <input type="checkbox"/> Bathing/Shower | <input type="checkbox"/> Sleeping | <input type="checkbox"/> Lifting | <input type="checkbox"/> Writing |
| <input type="checkbox"/> Getting in/out of chair | <input type="checkbox"/> Brushing teeth | <input type="checkbox"/> Sitting | <input type="checkbox"/> Cooking | <input type="checkbox"/> Shopping |
| <input type="checkbox"/> Walking up/down stairs | <input type="checkbox"/> Dressing | <input type="checkbox"/> Standing | <input type="checkbox"/> Laundry | <input type="checkbox"/> Driving |
| <input type="checkbox"/> Getting in/out of shower | <input type="checkbox"/> Work Activities | <input type="checkbox"/> Walking | <input type="checkbox"/> Vacuuming | |
| <input type="checkbox"/> Other: _____ | | | | |

Patient's Signature: _____ **Date:** _____

I believe the above to be true and correct to the best of my knowledge

Therapist Signature: _____ **Date:** _____

I have reviewed the above information

Right to Share Information With Family and Friends

Florida Sports Orthopaedic & Spine Medicine Therapy Unit reserves the right to communicate Private Health Information (PHI) with family or friends when it is deemed in the best interest of the patient as described in the Notice of Privacy.

In order to have your PHI shared in other circumstances with members of your family or friends please list those individuals that we are authorized to release information.

1. _____ Date: _____

2. _____ Date: _____

3. _____ Date: _____

4. _____ Date: _____

_____ Date: _____

PATIENT/PARENT (PLEASE PRINT NAME)

_____ Date: _____

PATIENT/PARENT (PLEASE SIGN NAME)

PATIENT UNABLE TO SIGN BECAUSE: _____

SIGNATURE OF PATIENT'S AUTHORIZED

REPRESENTATIVE(OTHER THAN PARENT) _____ Date _____

RELATIONSHIP TO PATIENT _____

WITNESS _____

Florida Sports Orthopaedic and Spine Medicine

Physical Therapy Unit

PHYSICAL THERAPY GUIDELINES

➤ **ARRIVE ON TIME FOR ALL APPOINTMENTS**

1. If you arrive 20 minutes late to an appointment, you will need to reschedule that visit for another time or may be seen for the remaining time in that hour only (Insurance co-pays are still collected in full)
2. If you arrive late for 3 appointments, your remaining visits will be cancelled and may be rescheduled at the discretion of the physical therapist.

➤ **IF YOU MUST CANCEL AN APPOINTMENT, PLEASE CALL TO LET THE THERAPIST KNOW AS SOON AS POSSIBLE, SO THAT YOUR TIME SLOT CAN BE FILLED BY OTHER PATIENTS NEEDING TO BE SEEN**

1. NO CALL/NO SHOW FOR AN APPOINTMENT – If you do not call to cancel or do not come in for an appointment, you are a no call/no show. If you no call/no show for 3 scheduled visits, you will be discharged from physical therapy and a note to the MD will also be sent informing him/her of your noncompliance with therapy

➤ **IF YOU ARE ILL, PLEASE CALL TO CANCEL YOUR APPOINTMENT, SO AS TO NOT GET OTHER PATIENTS OR STAFF MEMBERS ILL AS WELL**

1. Illness included fever, nausea/vomiting, diarrhea, contagious airborne cough/cold or flu symptoms.

➤ **PLEASE NOTIFY THE FRONT DESK OF ANY CHANGES TO YOUR INSURANCE POLICY OR PERSONAL INFORMATION (i.e. address, phone number, employer, etc.)**

➤ **PLEASE NOTIFY THE PHYSICAL THERAPIST OF ANY CHANGES TO YOUR MEDICAL HEALTH OR CONDITION (i.e. hospitalization, new medications, falls, new injuries, etc.) AS WELL AS ANY UPCOMING APPOINTMENTS WITH YOUR REFERRING PHYSICIAN**

Patient Signature

Date

**ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR PRIVATE
AND GROUP ACCIDENT AND HEALTH INSURANCE**

Patient: _____

Employer Name: _____

Ins ID # or SS#: _____

Group #/Claim #: _____

I hereby instruct and direct my Insurance Carrier(s) / Medicare to pay by check made out and mailed to: **Choi, Hanff,
Mirabello, Shim, and Torke, LLP**

OR

If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct , my insurance company to make the check to me and mail it as follows:

C/O

**Choi, Hanff, Mirabello, Shim, and Torke,LLP
Florida Sports Orthopaedic and Spine Medicine
Physical Therapy
3890 Tampa Rd. Suite 202
Palm Harbor, Fl 34684**

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THEIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Date

Patient Signature / Financially responsible Party

Printed Patient Name / Financially Responsible Party

Notice of Privacy Practices for Protected Health Information (HIPPA)

“This Notice Describes How Medical Information About You May Be Used And Disclosed And How You May Get Access To This Information”.

We Safeguard Information About Your Health And Person:

We collect information from you and store it in a medical record as well as on a computer. Charts are stored in a secure area and available only to designated staff and only for designated reasons. Housekeeping, maintenance and other non-office personnel have no access to the chart area. Service technicians may have access to the computer, but only for service of computer operations.

Typical Uses And Disclosures Of Medical Information:

WE collect medical information from you. Within our office, we restrict the disclosure of this information to doctors, nurses, technicians and insurance and billing personnel. We may use your medical information for treatment and care, payment to insurers and for healthcare operations. Outside our office, we restrict the disclosure to those people, entities and agencies for whom you authorize disclosure such as other healthcare providers (doctors, nurses, extended care facilities), insurance companies, billing agencies, hospitals, and surgery sites, or those agencies and entities for whom legal and administrative requirements demand disclosure such as:

- When required by law
- Public health activities (deaths, child abuse, neglect, domestic violence, problems with product, reactions to medications, product recalls, disease/infection exposure, disease/injury/ disability control/prevention)
- Health oversight activities (audits, investigations, inspections)
- Judicial and administrative proceedings (court order)
- Appropriate law enforcement requests (to identify or locate a suspect, fugitive, material witness, or missing person)
- Deceased person information to coroners, medical examiners, funeral directors.
- Research, provided authorization is IRB-approved or privacy board-approved
- Emergencies or to avert serious threat to health or safety
- Specialized government functions (military, inmates)
- Worker’s compensation
- Disaster Relief

We will not use or disclose your medical information for any purpose not listed without your specific written authorization. Any specific written authorization you provide may be revoked at any by writing to us.

You Have The Right To:

- Inspect and copy medical information from your chart. You may submit a written request to our office and pay the copy fee and receive a copy of your record. We must respond within 30 days if the record is readily available and within 60 if it is not readily available.
- Amend medical information in your chart. You may identify inaccurate or incomplete information in your chart. You can do this with a written request to amend your chart directed to our office. We must respond within 60 days.
- Receiving an accounting of any disclosures made from your record over the last six years, starting April 14, 2003. You can get this with a written request directed to our office. WE must respond within 60 days.
- Request restrictions as the amount of medical information we disclose. This is limited as noted above, and your request may not supercede the typical disclosures noted above. You may revoke or restrict consent.
- Request confidential communications. All communications in our office are confidential. You may specifically-request that all communications be confidential with a written request directed to our office.
- Receive a copy of this notice by printing it or with a written request directed to this office, and a copy of this notice will be given with all new patient packets.

We may contact you for appointment reminders, and we may provide you with information about health-related or product benefits and services.

Each patient is given a copy of the Privacy Notice and an opportunity to review and understand it.

Our Responsibilities Under HIPPA:

We are required by Law to maintain the privacy of your persona; health information, and to provide you notice of our legal duties and privacy practices and adhere to this notice. We reserve the right to make changes to this notice. We will post a notice that the notice has been changed and the effective date of the change, copies will be made available.

You can submit a complaint about our privacy policy or its execution either verbally or in writing to our Privacy Officer at our office:

Florida Sports Orthopaedic and Spine Medicine

3890 Tampa Rd. Ste. 202

Palm Harbor, Fl 34684

Ph: 727-787-5577

Fx: 727-781-5927

If you get no resolution to your complaint, you can send a written statement to this office or the Secretary of Health and Human Services.

Effective Date of Notice: January 2008

Amended Date: