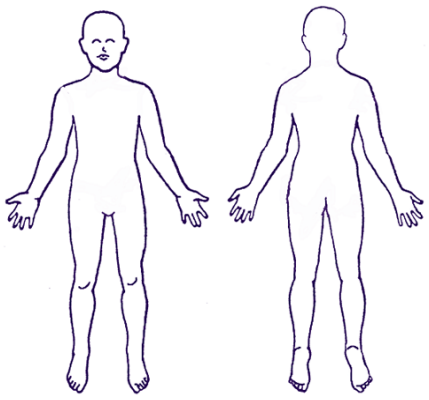
1. Where is your pain/problem? (Please mark area on diagram right.)



2. What caused your pain/problem?
   _____
3. Approximately when did it start? ___/____/_____
4. Have you ever had this problem before? _____
5. Have you had any treatment for this condition?
   _____
6. Have you had any radiographic tests (x-rays, MRIs, etc)?
   _____
7. What specific activities are you having difficulty with because of your condition?
   _____
8. On the scale below, *circle* your worst pain level over the in the past few days where 0 is mild and 10 is severe:

   0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10
9. Is the pain constant? (never goes away) _____
10. Is it getting worse, better, or staying the same? _____
11. Are you taking medication for this problem? Yes No **If yes, please include in the next section.**
    Does it help? _____
12. **List all medications you are taking and INCLUDE DOSAGE (required for insurance)**. If you have a list with you, let us know and we will make a copy for you.
    _____
    _____
    _____
    _____
13. List all medical conditions you have (even if managed with medication):
    _____
    _____
    _____
    _____
14. List all surgeries you have had with dates: _____
    _____
    _____
15. Are you involved in a regular exercise program? Yes No
    If yes, what and how often? _____
16. Patient Height: _____ Patient Weight: _____ Employment status: _____
17. Are you experiencing symptoms of Depression? Yes No If yes, is your physician aware? _____

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**Printed Name:** _____ **Signature:** _____ **Date:** _____

**Emergency Contact Name:** _____ **Relationship:** _____

**Emergency Contact Phone Number:** _____

# Siesta Key SPORTS & PHYSICAL THERAPY

## Appointment Cancellation and Payment Policy

Dear Patient,

Thank you for trusting your physical therapy care to Siesta Key Sports & Physical Therapy. We take great pride in offering only the highest quality of service and always strive for the best functional outcomes for you, your family, and all of our patients. In order to produce your best success, we use a scheduled appointment system that ensures one-to-one time for each and every patient.

If you are late, do not show up for your reserved appointment, or do not notify us of your inability to keep your appointment by phone at least 24 hours in advance, we will not be able to treat another patient and this time is lost to other patients, our office, and staff. With this in mind, an Appointment Cancelation Policy has been put into place.

### Our Cancellation Policy is as follows:

1. We request that you kindly give our office 24-hour notification in the event that you need to reschedule your appointment. This will give us enough time to make your appointment time available to another patient in need. If we are not open, please leave a message with the time that you are calling and when you might be available to reschedule your appointment.

2. If you miss your appointment or call on short notice and we are unable to fill your reserved appointment time, we will consider this to be a missed appointment and a charge of $50.00 will be assessed to you.

3. If you are late for an appointment, we will try to accommodate you if possible. If there is not adequate time, your appointment will be rescheduled and you will be charged for the missed visit.

### Our Payment Policy is as follows:

1. All payments are expected at the time services are rendered.
2. Patients who are not using insurance to pay for their PT are classified as self-pay. Due to high credit card processing fees and in an effort to keep our self-pay rates low, check or cash are the preferred payment options.
3. If you are unable to pay by check or cash, we will accept credit card payments with a 4% processing fee.
4. Patients using insurance may pay by check, cash or credit card; although check and cash are preferred.

If you have any questions regarding this policy, please do not hesitate to ask our office manager.

### I have read and understand the Cancellation and Payment Policies and agree to the terms.

_____ _____

Signature (Patient/ Legal Guardian) Date

_____ _____

Printed Name

# Siesta Key Physical Therapy, LLC

## Consent and Privacy Notice

PLEASE INITIAL EACH STATEMENT *

*_____(initials) **CONSENT TO TREATMENT**: I consent to rehabilitation and related services at SIESTA KEY PHYSICAL THERAPY. I understand that it is my right to accept or decline any services offered to me. I acknowledge that no guarantee has been made as to the results that may be obtained from such treatments. I understand that such services may involve direct contact of a sensitive nature

*_____ (initials) **AUTHORIZATION OF PAYMENT**: I request that payment of the Medicare/Insurance benefits be made on my behalf to SIESTA KEY PHYSICAL THERAPY for any services rendered to me by SIESTA KEY PHYSICAL THERAPY. I hereby assign all benefits directly to SIESTA KEY PHYSICAL THERAPY and also authorize release of any medical records necessary to facilitate my treatment or process medical claims and otherwise permitted in the Notice of Privacy Practices. SIESTA KEY PT or MBA may verify insurance benefits on my behalf. Verification is no guarantee of payment. The agent/patient is responsible for any co-payment, deductible, coinsurance, and all amounts identified by the insurer as the patient's responsibility. I understand that in the event that my insurance company or financially responsible party does not pay for the services I receive, I will be responsible for payment

*_____ (initials) **WAIVER AND RELEASE**: I hereby release, discharge, and acquit SIESTA KEY PHYSICAL THERAPY, its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive, or allow emergency and or medical services, including by not limited to ambulance, EMT, physician, or urgent care services.

*_____ (initials) **LIABILITY:** I know and agree that SIESTA KEY PHYSICAL THERAPY is not responsible for loss or damage to personal items.

*_____ (initials) **TREATMENT OF MINORS**: I, as parent/guardian of a minor receiving treatment hereunder, do agree and understand that I have been advised to remain on the premises during such treatment, and waive any claim I may have resulting from failure to do so.

*_____ (initials) **PHOTOGRAPHY CONSENT:** I hereby grant SIESTA KEY PHYSICAL THERAPY to take and use photographs, video, and/or digital images for use in websites or other electronic communications, news releases and/or educational materials. I authorize the use of these images without compensation to me. All prints, video, and digital reproductions shall be the property of SIESTA KEY PHYSICAL THERAPY.

**NOTICE OF PRIVACY PRACTICES:** The Healthcare Insurance Portability and Accountability Act of 1996 ("HIPPA") is a federal program, which requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

We are required by law to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to protected health information.

As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for our visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example of this would be an internal quality assessment review.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations.

Patient Name (Please Print): _____ Date _____

Patient Signature: _____ Witness Signature: _____