Patient History Form

Personal Information:

Full Name: _____

Date of Birth: _____

Gender: _____

Address: _____

City,State, Zip Code: _____

Phone Number: _____

Email Address: _____

Emergency Contact Information:

Emergency Contact Name: _____

Relationship to Patient: _____

Phone Number: _____

Primary Physician Information:

Physician's Name: _____

Phone Number: _____

Insurance Information:

Insurance Provider: _____

Insurance ID Number: _____

Auto case Injury or Workers compensation case? If yes, please specify:

_____

Medical History:

Please check all that apply or provide additional details as necessary.

1. Area of Symptoms: _____

2. Do you have any current medical conditions? If yes, please specify:_____

3. Have you had any surgeries or significant injuries in the past? If yes, please provide details:_____

4. Any known results of recent radiographs, MRI, CT, PET or other tests?_____

5. Do you have any known allergies? If yes, please specify: _____

6. Are you currently taking any medications? If yes, please list the medications and their dosages: _____

7. Have you previously received physical therapy? If yes, please provide details:_____

8. Do you have any mobility aids (crutches, walker, wheelchair, etc.)? If yes, please specify:_____

9. Do you experience any pain or discomfort? If yes, please describe the location, intensity, and any triggering factors: _____

10. How would you rate your ability to perform routine daily activities?
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

11. How would you rate your current pain? None 0 1 2 3 4 5 6 7 8 9 10 Emergency Room

12. Are there any specific activities or movements that aggravate your symptoms? If yes, please specify: _____

13. Are you currently experiencing any limitations in your daily activities or mobility? If yes, please provide details: _____

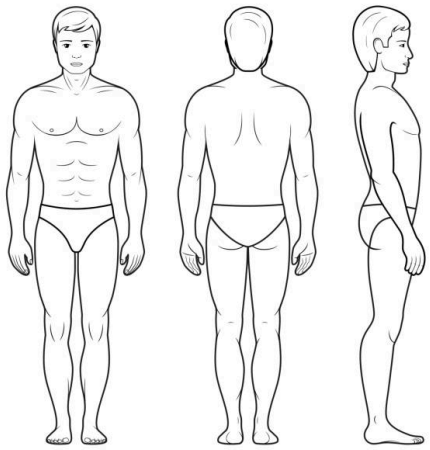
14. Is there any other information or medical history that you believe is important for us to know? _____

Check all that apply

- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy or Seizures
- ☐ Heart Disease
- ☐ Blood Disorders
- ☐ HIV/AIDS
- ☐ High Blood Pressure
- ☐ Metal Implants
- ☐ Respiratory Problems
- ☐ Osteoporosis
- ☐ Are you pregnant?
- ☐ Smoker

Please draw your pain on the body to the right using the following symbols:

/// Stabbing Pain
XXX Burning
000 Pins and Needles
=== Numbness



Consent and Signature:

I hereby certify that the above information is accurate and complete to the best of my knowledge. I understand that this information will be used for the purpose of providing appropriate physical therapy treatment.

Patient's Signature: _____

Date: _____

Release of Medical Information:

I authorize South Florida Rehab & Training Center to release my medical information, including but not limited to diagnosis, treatment records, and billing information, to my insurance provider, healthcare providers involved in my care, and any necessary third parties for the purpose of processing claims, obtaining payment, and coordinating my treatment.

Patient's Signature: _____

Date: _____

Media Release:

I hereby grant permission to South Florida Rehab and Training Center to use photographs, videos, and other media of my child taken during the for promotional purposes, including but not limited to the organization's website, social media platforms, and printed materials.

Parent/Guardian Signature: _____

Date: _____

Assignment of Benefits/Consent to Treatment:

I hereby assign and authorize direct payment of insurance benefits to South Florida Rehab & Training Center Inc. for services rendered to me. I understand that I am financially responsible for any charges not covered by my insurance plan. I also consent to receive necessary physical therapy treatment as recommended by the clinic's healthcare professionals. Treatment only covers one body part at a time.

Credit Card Authorization

I authorize my credit card to be charged for the amount I am responsible for each of my services. A receipt can be provided for me at anytime requested. Failure for payment to be collected will result in the amount being sent to collections.

Credit card #: _____ EXP date: _____

Patient's Signature: _____

Date: _____

Policies

1. We recommend scheduling at least 3 days in advance as we do get booked quickly.
2. Insurance only covers 1 Body part at a time (additional cost may apply for any extra modalities). Please talk to your therapist before treatment.
3. Copayment/ Coinsurance is due upon arrival of a patient's appointment.
4. Any products, or PACKAGES, purchased at SFR are NON-REFUNDABLE. If approved for a refund, it will be processed and distributed to the patient after the patient has been discharged from their case the credit is applied.
5. 24-HOUR NOTICE CANCELLATION/NO SHOW will be charged a $25.00 fee. Reminder texts are solely a courtesy.
6. All packages have a 60-day expiration from the date of purchase. •
7. Appointments scheduled Black Friday, New Years Eve, Christmas Eve, Monday following Super bowl Sunday & and any Saturday MUST be paid at the time the appointment is made.
8. We are a facility that partners with medical and nursing schools, education programs and research centers to improve health care through learning and research.

Consent to Treat Minor:

I, [Parent/Guardian Name], am the parent or legal guardian of the above-named minor participant. I hereby authorize South Florida Rehab and its representatives to seek and obtain any necessary medical treatment for the minor during the duration of the [Camp Name] Summer Baseball Camp. I understand that efforts will be made to contact me in case of an emergency, and I will be responsible for any medical expenses incurred.

Parent/Guardian Signature: _____

Date: _____

Notice of Privacy Practices:

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS VERY IMPORTANT.

LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect on January 1, 2013, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. I reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make significant changes in our privacy practices, we will change this Notice and make the new Notice available upon request.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you in connection with treatment, payment and healthcare operations, for example:

Under no circumstances will protected health information be released (verbally or written) without first obtaining a written

"Release of Information Consent" form that is signed by the patient or in the case of a minor, his/her legal guardian. The only exception to the aforementioned would be in life or death situations, or those circumstances mandated by law.

In an effort to assist you in processing, coordination and managing your healthcare operations, (for example: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, etc.)

We, upon your request and signed consent, will provide you with a claim form for your submission to your insurance company and will assist you in other related insurance matters. By signing the patient information sheet, you are authorizing us to carry out these functions on your behalf, only upon your request. We do not submit any electronic billing nor do we accept assignment of benefits. Please be aware when a claim form is generated, a diagnosis is given.

Any communication with other healthcare providers, schools or other agencies regarding your healthcare information will only upon your request and a written "Release of Information Consent" form has been signed.

The privacy of your protected health information is very important. We understand that your medical information is personal and we are committed to protecting it!

You may obtain a copy of our Notice of Privacy Practices, including any revision of our Notice, at any time by contacting:

South Florida Rehab & Training Center Inc.

(305) 905-4188

info@southflcenters.com

Right to Revoke. You will have the right to revoke any release of information consent form that you have signed at any time by giving us a written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of consent will not affect any action we took in reliance to

consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.
I have had a full opportunity to read and consider the contents of this form and
your Notice of Privacy Practices, I understand that by signing this form. I am giving my consent to your use and disclosure of my protected health information in connection with treatment, payment activities and healthcare operations.

I acknowledge that I have received a copy of the Notice of Privacy Practices, which explains how my health information may be used and disclosed, and my rights regarding my health information under the Health Insurance Portability and Accountability Act (HIPAA).

Patient's Signature: _____

Date: _____

Please complete this form and bring it with you to your initial appointment. If you have any changes to your medical history in the future, please inform our staff. Thank you for providing us with the necessary information to better serve you during your physical therapy treatment.

SFR
SOUTH FLORIDA REHAB
PHYSICAL THERAPY + TRAINING
CENTER