Worker's Compensation Questionnaire

Please answer all questions completely

Name _____ Sex _____ Marital Status _____ DOB _____

Address _____ City_____ State _____ Zip _____

Home Phone _____ Alternate Phone _____

Occupation _____ Who referred you to our office? _____

(Please Indicate if child, student, housewife, unemployed, retired)

SSN _____ Business Phone _____ Company Name _____

Location _____ Have you returned to work? _____ Any weight restrictions? _____

Please explain in detail how your accident happened _____

_____

_____

_____

Have you retained an attorney? ❑ Yes ❑ No Litigation? ❑ Yes ❑ No ❑ Maybe

If so, name and address _____

Time and date present injury occurred _____ ❑ AM ❑ PM _____ 20_____

Where did you feel pain immediately after the accident? _____

Did you return to work afterwards? ❑ Yes ❑ No If so, date returned to work _____

Did you consult any doctor? ❑ Yes ❑ No

If so, doctor's name _____ ❑ D.C., ❑ M.D., ❑ D.O., ❑ D.D.S.

Doctor's Diagnosis _____

What treatments did you receive? _____

Have you ever injured this area before? ❑ Yes ❑ No If so, when? _____

If injured before, did you lose time from work? ❑ Yes ❑ No

If you lost time from work with injuries prior to this injury, give the name of doctor or doctors consulted _____

_____

Do any other diseases or accidents affect your employment? ❑ Yes ❑ No If so, explain _____

_____

In your work do you have to favor any part of your body? ❑ Yes ❑ No If so, explain_____

_____

Do you have a history of absenteeism caused from accidents on the job? ❑ Yes ❑ No

Have you ever had a Worker's Compensation claim before? ❑ Yes ❑ No

Before the injury were you capable of working on an equal basis with others your age? ❑ Yes ❑ No

Are your work activities restricted as a result of this accident? ❑ Yes ❑ No

Since this injury are your symptoms ❑ improving? ❑ getting worse? ❑ the same?

Billing & Insurance Policy

If you have insurance we will gladly process it for you as a patient courtesy, however, we do require that you pay your estimated portion at the time service is rendered, unless other arrangements are made with us. If we have not received payment from your insurance company within 120 days, we will send you an invoice for the balance.

I understand that this release and assignment may be revoked by me at any time and, in any event, will expire two years from this date. I authorize Florida Physical Therapy & Wellness Center, LLC to treat me for my physical therapy as prescribed by my physician. I hereby agree to pay any portion of the charges by Florida Physical Therapy & Wellness Center, LLC, that are not covered by insurance or government programs. If Florida Physical Therapy & Wellness Center, LLC does not receive 20% of the payment from me within 30 days, and my account becomes past due, I will be responsible for the collection costs. In the event that the insurance company sends the check directly to me for therapy services rendered at Florida Physical Therapy & Wellness Center, LLC, I agree to bring the payment with the explanation of benefits (EOB) to Florida Physical Therapy & Wellness Center, LLC.

In signing this agreement, I understand and comply with this policy.

Signature: _____ Date: ____/____/____

THIS PROVIDER OF MEDICAL SERVICES IS AN EQUAL OPPORTUNITY EMPLOYER AND DOES NOT DISCRIMINATE IN ITS PROFESSION OR EMPLOYMENT ON THE BASIS OF RACE, CREED, SEX, NATIONAL ORGIN, AGE OR HANDICAP.

Patient Consent for Use and Disclosure of Protected Health Information

I give my consent for Florida Physical Therapy & Wellness Center, LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Florida Physical Therapy & Wellness Center, LLC's Notice of Privacy Practice provides more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Florida Physical Therapy & Wellness Center, LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Florida Physical Therapy & Wellness Center, LLC, 2575 Kurt Street, Ste 106, Eustis, FL 32726. With this consent, Florida Physical Therapy & Wellness Center, LLC may mail to my home or other alternative location any items that assist in the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Florida Physical Therapy & Wellness Center, LLC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree with my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting Florida Physical Therapy & Wellness Center, LLC's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not consent or later revoke it, Florida Physical Therapy & Wellness Center, LLC may decline to prove treatment to me. I certify that I have received a copy of Florida Physical Therapy & Wellness Center, LLC's ("FPTWC") Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of FPTWC's health care operations. The Notice of Privacy Practices is also posted in the Front Desk area. FPTWC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Legal Guardian

_____ Date: ____/____/____

Release Authorization Form

Patient Name (Print): _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

By signing this Authorization Form, I understand that I am giving my authorization to Florida Physical Therapy & Wellness Center, LLC (FPTWC)'s designated medical record custodians, database custodians, central billing/collections office personnel to use and/or disclose my protected health information (PHI), as described in more detail in the paragraph below, to the following person(s) or organization(s):

Name of Person(s) or Organization(s): _____
Street Address: _____
Telephone Number: _____
Fax Number (if applicable): _____
If Person, relationship to patient: _____

If this authorization is for any purpose other than the release of medical records for personal reasons, please state the purpose of the authorization to release PHI below: _____

_____

I may revoke this authorization at any time by notifying FPTWC in writing to 2575 Kurt Street, Suite 106, Eustis, FL 32726 of my intent to revoke this authorization. However, I also understand that such a revocation will not have any effect on any information already used or disclosed by FPTWC before FPTWC received my written notice of revocation. Unless earlier revoked, this authorization will expire on the 180th day of the signing (or as otherwise specified: _____).

_____ Date: _____/_____/_____
Signature of Patient or Personal Representative

_____
Name of Patient of Personal Representative

CONSENT FOR TREATMENT IN A GROUP SETTING

Florida Physical Therapy & Wellness Center, LLC ("FPTWC"), in compliance with Federal HIPPA Regulation, is committed to protecting your health information and privacy.

It is our serious effort to ensure that your protected health information ("PHI") is kept private in a group setting. However, due to the setting of the open gym of the therapy areas, your treatment may be performed in the presence of other individuals. In some cases, other patients, family members or friends and our staff will overhear information relating to your treatment, diagnosis and insurance benefits.

Unless you indicate in writing to the contrary, by signing this Consent For Treatment Form, you are agreeing that it is possible for other patients to overhear trivial information regarding your treatment and consenting to the disclosure of this inconsequential information to any other individuals who may be present in the therapy area.

By signing below, I acknowledge and agree to the above conditions.

_____ _____ _____/_____/_____

Signature of Patient (or authorized rep) Print Name of Patient Date

If representative signs, please explain representative's relationship to patient and include a Representative's authority to act on behalf of patient: _____

_____

_____

Cancellation/No-Show Policy

Thank you for choosing us. Your successful rehabilitation is very important to us. In order to achieve the best possible outcome, we, with your doctors, have recommended a treatment schedule. To get you the desired results, it is very important that you attend each of your therapy appointments.

We reserve time for each of our patients in order for them to complete their plan of care successfully. With this in mind, we ask for your cooperation by making every effort to keep your scheduled appointments.

Please take a moment to review our guidelines put into place to ensure you get the most out of your rehabilitation with Florida Physical Therapy and Wellness Center.

- Please give us at least a 24-hour notice in the event you need to cancel. If you do not call, you are considered a NO SHOW. NO SHOW/NO CALLS will be charged a $50.00 cancellation fee. This amount will be billed *to you directly*, as your insurance company *will not* be responsible.
- You will be called after your first NO SHOW/NO CALL as a courtesy reminder, but any additional NO CALL/NO SHOWS will result in the removal from any further scheduled appointments. You will need to call to resume and reschedule your appointments. The accumulation of 3 NO SHOW/NO CALLS will result in a discharge from the therapy program. You will need to get a new order from your referring physician before we will be able to schedule any further appointments.
- If you are more than 15 minutes late, you will most likely need to reschedule due to conflicting appointments. We want you to get the therapy you need and not interfere with another patient's scheduled time. Please call the office if you are going to be late so we can decide to either change your appointment time or check and see if being late will conflict scheduled patients.

Worker's Compensation and Personal Injury Patients: Your cancelled appointments are documented, as the case manager calls to verify each appointment that you are scheduled for. This could jeopardize your claim and prolong or stop any benefits you are entitled to.

PLEASE DO NOT CANCEL if you are feeling worse and believe treatment is not working. Keep your appointment and discuss any changes with your therapist. Please understand that your pain will probably fluctuate as your course of treatment progresses.

PLEASE DO NOT CANCEL if you are feeling better. Keep your appointment in order to progress your plan and prepare for discharge.

When you don't show as scheduled, three people are affected: You, because you don't get the treatment you need. The therapist, who now has a gap in his/her schedule since the time was reserved for you. And finally, another patient, who could have had your appointment time.

We are glad you are here. You are the reason our Physical Therapy practice exists and we are thankful to be able to work with you to improve your health.

I HAVE READ AND UNDERSTAND THE CANCELLATION AND NO-SHOW POLICY.

_____	_____	_____
Patient Printed Name	Patient Signature	Date

Medical History Form

Name: _____ Date: _____/_____/_____

Circle YES or NO (If you circle YES, please explain further on the provided line)

YES NO HISTORY OF HIGH BLOOD PRESSURE _____

YES NO HISTORY OF HEART BLOOD VESSEL DISEASE _____

YES NO PREVIOUS HEART ATTACK (MI) _____

YES NO PREVIOUS STROKE (CVA) _____

YES NO DIABETES _____

YES NO EPILEPSY _____

YES NO RESPIRATORY DIFFICULTIES _____

YES NO BROKEN BONES _____

YES NO NUMBNESS & TINGLING _____

YES NO ARTHRITIS OR JOINT PROBLEMS _____

YES NO SPECIAL DIET RESTRICTIONS _____

YES NO PRESENTLY HAVE ANY METAL IMPLANTS _____

YES NO CURRENTLY PREGNANT _____

YES NO ANY PRESENT VISUAL PROBLEMS _____

YES NO ANY PRESENT HEARING PROBLEMS _____

YES NO ANY UNSUAL REACTION TO HEAT OR COLD _____

YES NO ANY ALLERGIES _____

YES NO CURRENTLY HAVE A PACEMAKER _____

YES NO CURRENT MEDICATIONS: _____

_____

YES NO MAJOR HOSPITALIZATIONS/SURGERIES _____

_____

YES NO ANY UNUSUAL RECREATIONAL ACTIVITIES _____

YES NO ANY HISTORY OF CANCER _____

YES NO ANY HISTORY OF IMMUNE DISORDER OR COMMUNICABLE DISEASE _____

_____ ____/____/_____

Patient Signature Date

Rate Your Pain:

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
No Pain										Worse Possible Pain

Where is your pain now? Use the appropriate symbol below to mark the area on your body where you feel these described sensations. Include all areas affected by your pain, and mark the type and area of pain if it radiates or spreads to other areas.

A – ACHE	**O** – NUMB	**=** - PINS/NEEDLES	**X** – BURNING	**/** - STABBING