PREMIER
PHYSICAL THERAPY & SPORTS MEDICINE

Name:_____ Age:_____Occupation:_____Date:_____

Weight:_____ Height:_____

1. When did your present pain start?

_____

2. How did your pain start?

- ☐ Suddenly
- ☐ Gradually
- ☐ Lifting
- ☐ Twisting
- ☐ Falling
- ☐ Bending
- ☐ Pulling
- ☐ Injured at work
- ☐ Injured in auto accident
- ☐ Hit from behind
- ☐ Sports injury
- ☐ Unknown

3. What makes it worse?

- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Kneeling
- ☐ Reaching Overhead
- ☐ Bending forward
- ☐ Bending backwards
- ☐ Lifting
- ☐ Squatting
- ☐ Other _____

4. What reduces the pain?

_____

5. Have you had any of these diagnostic studies?

- ☐ X-ray
- ☐ CT Scan
- ☐ Doppler US
- ☐ MRI
- ☐ EMG/NCV

6. What were the results of the diagnostic studies?

_____
_____
_____

7. Have you received treatment for this condition?

- ☐ No
- ☐ Yes
  - ☐ Physical Therapy
  - ☐ Chiropractor
  - ☐ Pain Management
  - ☐ Injections
  - ☐ Surgery

Please Describe: _____
_____
_____

8. Do you have any of the following conditions?

- ☐ Heart
- ☐ Blood Pressure
- ☐ Cancer
- ☐ Metal Implant
- ☐ Recent Weight Loss
- ☐ Pacemaker
- ☐ Fibromyalgia
- ☐ Other
- ☐ Diabetes
- ☐ Cholesterol
- ☐ Arthritis
- ☐ Pregnant
- ☐ Bowel or Bladder
- ☐ Thyroid
- ☐ Loop monitor

If any checked above please describe:

_____
_____
_____

9. Do you smoke?

- ☐ No
- ☐ Yes How Much? _____Packs/Week

10. Do you consume alcoholic beverages?

- ☐ No
- ☐ Yes How Much? _____ Beverages/Week

11. Have you had any past surgical procedures?

- ☐ No
- ☐ Yes Please List:_____

_____
_____
_____
_____

12. Have you recently been hospitalized?

- ☐ No
- ☐ Yes When and what for?_____

_____
_____
_____
_____

13. Do you have any allergies?

_____
_____
_____
_____

By signing this document, I am stating I have read and agree to the above policies.

_____ _____

Signature Date

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Patient Information

Name _____ Date of Birth _____

Social Security # _____ ☐ Male ☐ Female

Address _____

City _____ State _____ Zip Code _____

Alternate Address if applicable _____

Phone Info: Home _____

Cell _____

Work _____

E-mail Address: _____

How were you referred to us? _____

Emergency Contact

Name _____ Phone _____ Relation _____

Work Information

Employer _____

Employer's Phone _____

Health Insurance

Primary _____ ID# _____ Group _____

Subscriber's Name _____ Date of Birth _____ Relation _____

Secondary _____ ID# _____ Group _____

Subscriber's Name _____ Date of Birth _____ Relation _____

Is this injury due to an auto accident? YES NO Initial: _____

Is this injury due to a work related accident? YES NO Initial: _____

Have you had physical therapy during this past year? YES NO Initial: _____

Are you currently receiving home health care? YES NO Initial: _____

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COVID-19 PRE-SCREENING QUESTIONS

Dear Patient/Visitor:

We appreciate your participation in completing and answering the screening questions to determine any risk for exposure to the COVID-19 virus. These screening questions will need to be completed by patients until the CDC states that the virus in no longer a threat. Our main goal is to protect the health of our patients, visitors, staff and will take every measure to ensure everyone's safety.

Patient/Visitor Name: _____ DOB: _____

1. Do you have any of the following symptoms? Please circle any that apply:
   Fever Cough Shortness of Breath
2. Have you traveled out of state in the last 30 days. YES or NO
   If yes, where:_____
3. If yes, did you travel by cruise/airplane/vehicle? _____
4. To your knowledge, have you been in contact with any individual diagnosed with COVID-19 (coronavirus) in the past 14 days? YES or NO
5. Will you be traveling out of state in the next month, and if so, what will be your mode of transportation?_____

If any of the above questions were to change over my next patient visits, I will make sure to inform you so that Premier can make any of the necessary changes to my schedule, Initials:_____

Please sign below and turn back into Premier Physical Therapy staff. Thank you for your assistance.

_____ _____
Patient/Visitor Signature DATE

www.Premier-Therapy.com

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AUTO INJURIES, WORK INJURIES and PERSONAL INJURIES ONLY – please complete this section

INJURY DATE: _____ INJURY TYPE: ☐ Work ☐ Auto ☐ Slip / Fall ☐ Other

If work related, did you report this to your employer? ☐ YES ☐ NO Claim#_____

If an auto accident, in what state did the accident occur? _____

Have you filed a claim for this injury? ☐ YES ☐ NO Claim#_____

Insurance Company _____ Phone_____

Address _____ Contact Person_____

Do you have an attorney? ☐ YES ☐ NO Name_____

Missed Appointment Policy

ALL PATIENTS PLEASE READ:

- Make every effort to attend all or your scheduled therapy sessions. This will speed your recover process.
- If you are unable to attend an appointment, please let us know 24-hours in advance so we can offer your treatment time another patient and get your appointment rescheduled to a more convenient time.
- There is a $25.00 charge for missing an appointment without cancelling.
- If you miss two or more appointments without cancelling, we reserve the right to cancel all of your future appointments and require that you obtain a new referral from you physician to re-start treatment.

INITIALS _____

WORKERS COMPENSATION PATIENTS PLEASE READ:

- Make ever effort to attend all of you scheduled therapy sessions. this will speed your recovery process.
- If you are unable to attend an appointment, please let us know 24-hours in advance so we can offer your treatment time to another patient and get your appointment rescheduled to a more convenient time.
- If you miss two or more appointments without cancelling, we will notify your physician, workers compensation insurance carrier and your employer that you are not attending your scheduled appointments. We also reserve the right to cancel all of your future appointments and require that you obtain a new referral from your physician to re-start your treatment.

INITIALS _____

Consent to Treat

I, the undersigned, hereby voluntarily authorize Premier Physical Therapy & Sports Medicine to perform outpatient diagnostic evaluation and/or procedures and to administer such outpatient therapy that is necessary and appropriate. I understand that physical therapy is not an exact science and no guarantee has been made as to the result of any treatment or care administered.

Authorization to Release Information

I, the undersigned, hereby voluntarily authorize Premier Physical Therapy & Sports Medicine and the attending physician to release information relative to any outpatient therapy treatment administered to any third-party payor(s) financially responsible for these services or my referring and/or primary care physician or therapist.

Acknowledgment of Terms

By signing below, I attest that all the information given is true and accurate to the best of my ability and that I have read and understand the policies stated above.

PATIENT SIGNATURE:_____ Date:_____

WITNESS SIGNATURE:_____ Date:_____

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NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGMENT OF RECEIPT

By signing this form, you acknowledge receipt of the ***Notice of Privacy Practices of PREMIER PHYSICAL THERAPY & SPORTS MEDICINE, INC.*** Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

If you have any question about out *Notice of Privacy Practices,* please contact our Compliance Office at:
1400 SE Goldtree Dr., Suite 205 • Port St. Lucie, FL 34952 • Ph. (772) 335-7966

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting us at the above address or our Practice.

I acknowledge receipt of the ***Notice of Privacy Practices of PREMIER PHYSICAL THERAPY & SPORTS MEDICINE, INC.***

Signature:_____ Date:_____
(Patient / Parent / Conservator / Guardian)

INABILITY TO OBTAIN ACKNOWLEDGMENT

To be completed only if no signature is obtained. If is is not possible to obtain the individual's acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgment, and the reasons why the acknowledgment was not obtained.

Signature of Provider Representative:_____ Date:_____

Acknowledgment was not obtained because:

- ☐ Patient refused to sign.
- ☐ Patient was unable to sign or initial because:

_____

- ☐ There was a medical emergency (the staff member will attempt to obtain acknowledgment at the next available opportunity).

Other reason(s): _____

_____

_____

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MEDICATION/OVER THE COUNTER/SUPPLEMENT NAME	DOSAGE	FREQUENCY	ROUTE OF ADMINISTRATION (i.e. oral)

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YOU ARE RESPONSIBLE FOR:
Payment for all services rendered by Premier Physical Therapy & Sports Medicine. Although we will do our part to submit claims to your insurance company, it is your responsibility to know your benefit and coverage limits. **If for any reason your insurance fails to reimburse Premier Physical Therapy & Sports Medicine you will be responsible for payment for all services rendered.**

PRE-AUTHORIZATION AND REFERRALS:
It is your responsibility to know which services require pre-authorization. If your insurance plan requires a written referral from your Primary Care Physician (PCP) in order for physical therapy services to be initiated, you are required to provide this facility with the written referral prior to your first treatment.

INSURANCE PLANS WITH DEDUCTIBLES:
If you have an annual deductible, in which you must pay before your insurance company begins to cover services rendered, you will be responsible to make payment in full for all services rendered until you deductible has been met.

PLANS OF NON-PARTICIPATION:
We will provide the service of submitting claims to you insurer if we are non-participating. However, if payment is not received within 90 days from the date of service, charges for services rendered to you or your family member become your responsibility. You are responsible for your entire charge less any payment from you insurer. If we do no participate with your secondary (or any non-primary) insurer, you are responsible for that portion of the bill at the time of service.

COVERAGE LIMITATIONS OF YOUR HEALTH INSURANCE PLAN:
Your health insurance plan provides payment for physical therapy services with the following limitations:

PAYMENT TERMS:
Payment is due at the time of service for insurance co-payments, annual deductibles and any services deemed non-covered by your insurance company. We accept Cash, Check Money Orders, MasterCard, Visa, Discover and American Express.

FEES: Insufficient Funds Check Fee $25.00 Missed Appointment Fee $25.00

IN SIGNING THIS POLICY:
You assign your insurance benefits directly to Premier Physical Therapy & Sports Medicine. You authorize Premier Physical Therapy & Sports Medicine to release any medical information for claims reimbursement or clinical purposes. You certify that all information given by you is correct to the best of your knowledge. Your signature on this document serves as "Signature On File"for all claims submitted to your insurance company for the services rendered at Premier Physical Therapy & Sports Medicine.

PATIENT SIGNATURE:_____ Date:_____

GUARDIAN SIGNATURE:
(if patient is a minor) _____ Date:_____

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Physical Therapy Attendance Policy (Please read thoroughly)

Premier Physical Therapy and Sports Medicine Inc strives to provide each patient with the highest level of quality care while attempting to accommodate your schedule for your convenience. Therefore, we provide reserved time slots for each patient with a specific therapist in order to minimize your waiting and assure continuity of your treatment. Your consistent attendance of the planned treatment regimen is paramount to your full recovery.

While we are sensitive to the fact that an emergency may occur in a rare instance, cancellations less than 24 hours prior to treatment along with patient no-shows, decrease our ability to accommodate the scheduling needs of the other patients. It also affects how we staff each location. Additionally, keeping your scheduled appointments is courteous to your therapist and other patients alike. We must ask for your full cooperation with the following policy:

- If you are more than 30 minutes late for your appointment and fail to notify us, treatment may be canceled, and a **$25** fee charged for missing the appointment.
- A scheduled appointment MUST BE CANCELED AT LEAST 24 HOURS IN ADVANCE, or the fee will be charged for that appointment.
- Failure to show up for an appointment ("NO SHOW") without notifying us will result in a fee being charged for that appointment. Furthermore, 2 consecutive no-shows will result in the cancellation of all remaining scheduled appointments.
- THE PATIENT IS RESPONSIBLE FOR THE FEE, NOT THE INSURANCE/THIRD PARTY PAYER
- All cancellations and no-shows will be documented in your medical record and appropriately reported to your physician and insurance/third party payer.
- Repeated failure to comply with this ATTENDANCE POLICY will result in discharge from the practice. Your physician's office will be notified.
- ***No cancellation fee will be charged if the missed appointment is made up within the same week it was scheduled on a day you do not have another appointment scheduled.***

We believe that this policy is necessary for the benefit of all our patients, so that we may continue to provide high quality treatment and service to everyone. All the staff at Premier Physical Therapy and Sports Medicine appreciates your anticipated adherence and cooperation with this policy. We wish you the best of luck with your treatment. We are here to help you attain all your goals and optimize your returns to all your pre-injury activities.

_____ ____/____/____

Patient Acknowledgment/Signature Date