PREMIER
PHYSICAL THERAPY & SPORTS MEDICINE

Name: _____ Age: _____
Occupation: _____ Date: _____
Weight: _____ Height: _____

1. When did your present symptom start?
_____

2. How did your symptoms 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 (please write below)

_____

4. What reduces your symptoms?
_____
_____

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?
_____
_____
_____
_____

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NAME OF MEDICATION (including over the counter medications)	**DOSAGE**	**FREQUENCY THE MEDICATION IS TAKEN**	**ROUTE OF ADMINISTRATION** (i.e., ORAL)

Please fill out all your current medications in the table above. If you have a list of them, give it to the receptionist so they can make a copy for your chart. Thank you! 😊

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Patient Information

Name: _____ Date of Birth: _____

Social Security #: _____ Male/Female: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Contact Information

Cell: _____

Home: _____

Emergency Contact Information

Name: _____ Phone Number: _____ Relation: _____

Work Information

Employer: _____

Employer's Phone Number: _____

Please circle YES or NO and INITIAL for the following four questions:

1. Is this injury due to an auto accident? YES NO INITIAL: _____
2. Is this injury due to a work related accident? YES NO INITIAL: _____
3. Have you have physical therapy in the past year? YES NO INITIAL: _____
4. Are you currently receiving home health care? YES NO INITIAL: _____

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 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: _____

PREMIER
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Physical Therapy Attendance Policy (please read thoroughly)

Premier Physical Therapy and Sports Medicine 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. We must ask for your full cooperation with the following policy:

- If you are more than 15 minutes late for your appointment and fail to notify us, treatment may be canceled, and a **$50.00 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 **$50.00 fee** for therapy appointments, **$100.00 fee** for Pelvic Foor and Lymphedema appointments and **$300.00 fee** for FCE appointments. 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 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

PREMIER
PHYSICAL THERAPY & SPORTS MEDICINE

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 questions about out *Notice of Privacy Practices,* please contact our Compliance Office at:
1400 SE Goldtree Drive, 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 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:

a. Patient refused to sign.

b. Patient was unable to sign or initial because:

_____
_____

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

d. Other reason(s):

_____
_____
_____
_____
_____

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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) 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 for making payment in full for all services rendered until your deductible has been met.

PLANS OF NON-PARTICIPATION:
We will provide the service of submitting claims to your 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 your insurer. If we do not 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.

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: _____

PREMIER
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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
Workers Comp claim #: _____

If an auto accident, in what state did the accident occur? _____
Have you filed a claim for this accident? ☐ YES ☐ NO
Claim #: _____

Insurance Company: _____
Phone: _____
Address: _____
Contact Person: _____

Do you have an attorney? ☐ YES ☐ NO
Name of attorney: _____

WORKERS COMPENSATION PATIENTS PLEASE READ & INITIAL:

- Make every effort to attend all your scheduled therapy sessions. This will speed up 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 calling to cancel, 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 you to obtain a new referral from your physical to re-start your treatment.

INITIALS: _____