PATIENT HISTORY

Date:_____/_____/_____

Last name First name

Date of Birth: Age:

Contact:

Mobile Work Email

Primary Care Physician: Phone: ( )

MEDICAL HISTORY

Do you have /had any of the following medical illnesses please circle YES (Y) or NO (N)

High Blood Pressure	Y/N	HIV / AIDS	Y/ N	Rheumatoid Arthritis	Y/N
Heart Disease	Y/N	Respiratory Problems	Y/N	Osteoarthritis	Y/N
Pacemaker	Y/N	Asthma	Y/N	Vertigo	Y/N
Heart Attack	Y/N	Allergies	Y/N	Hearing Loss	Y/N
Stroke	Y/N	Recent Fever/Headaches	Y/N	Memory Loss	Y/N
Blood Clot / DVT	Y/N	Bowel / Bladder Changes	Y/N	Vision Loss	Y/N
High Cholesterol	Y/N	Kidney Problems	Y/N	Numbness	Y/N
Diabetes	Y/N	Anxiety / Depression	Y/N	Dermatitis	Y/N
Seizures	Y/N	Unexpected Weight Loss	Y/N	Hernia	Y/N
Cancer	Y/N	Pregnant	Y/N	Joint Replacement	Y/N
Hepatitis	Y/N	Osteoporosis	Y/N	Metal/Screws in body	Y/N

Please list any medications you are currently taking including over-the-counter, vitamins/supplements, herbals, other:

_____

_____

_____

FILL OUT THE FOLLOWING AS BEST AS POSSIBLE SO WE MAY BETTER ASSIST YOU

- ❑ **Please describe your primary physical complaint (i.e. Knee pain):**

_____

_____

- ❑ **What was your injury a result of (i.e. sports injury, lifting box at work):**

_____

- ❑ **How long ago did you injure yourself (i.e. one week ago) please list specific date if possible:_____**

- ❑ **Have you received any treatment for your condition by a Physical Therapist this year? If yes please provide the following: (YES/NO)**

  Healthcare provider who was seen:

_____

How many visits? _____

How did you hear about FIX IT PHYSICAL THERAPY ?
Healthcare provider:_____
Friend /Family:_____
Other(i.e. Facebook , Instagram)_____

Patient Treatment Consent Form

I acknowledge I am willingly giving my consent to undergo physical therapy treatment furthermore I am also aware and acknowledge in giving my consent to undergo physical therapy treatment I may also terminate treatment at any time.

I understand I have the right to address any concerns I may have and my right to ask any questions regarding my therapy during my treatment.

Patient name (Print)

Patient Signature **Date**

INFORMED CONSENT

I have received a Physical Therapy examination today by:

(_____)

Physical Therapist Name

And I have been informed of the following:

- ❑ **Diagnosis and/or problem needing treatment**
- ❑ **Treatment recommendation**
- ❑ **Side effects and/or potential risks of treatment**
- ❑ **Benefits anticipated from treatment**
- ❑ **Any possible alternatives for recommended treatment**

Patient name (Print)

Patient Signature **Date**

**MEDICARE PATIENTS ONLY **

OUTPATIENT THERAPY QUALIFICATIONS

Please answer the following questions in order to determine if you qualify for outpatient therapy services

Are you currently receiving assistance in your home from anyone other than a family member including Nurse Aide, Home Health Representative, or a Therapist (YES / NO)

In the last 30 days were you assisted in your home by anyone other than a family member including Nurse Aide, Home Health Representative, or a Therapist (YES / NO)

If yes please check the box for which you are receiving assistance

- ❑ **Physical, Occupational, or Speech Therapy**
- ❑ **Wound Care**
- ❑ **Injection or Medication**
- ❑ **IV Care**
- ❑ **Other Service_____**

As per the guidelines of Medicare If YES was selected to any of the questions above you MAY NOT BE ELIGIBLE to receive outpatient therapy services. To qualify for our services you are responsible for your discharge from all home care services PLEASE BE AWARE CHARGES MAY OCCUR AT THE DENIAL OF YOUR CLAIM WHICH YOU A RESPONSIBLE FOR

FINANCIAL RESPONSIBILITY & ASSIGNMENT OF BENEFITS
****ALL FINANCIAL RESPONSIBILITIES INCLUDE MEDICARE****

I understand that my insurance contract is between myself, my employer (if applicable), and the insurance carrier. I understand that FIX IT PHYSICAL THERAPY is not a party to the contract. I understand FIX IT PHYSICAL THERAPY must verify the benefits and services which I am covered under and to do so will contact my insurance carrier for verification. I certify I am providing accurate information regarding my insurance contract and other important information needed which is critical in the determination of my eligibility. I understand that the verification of benefits is a courtesy and I acknowledge that it is my responsibility to understand coverage and requirements under my insurance policy

I understand billing for services rendered will be sent to my insurance carrier furthermore I am aware if verified for benefits I am responsible for any financial responsibilities that may be subject to change and verification is not a guarantee of payment from my insurance carrier. I understand and acknowledge that I am personally responsible and guarantee personal payment for any services rendered that my insurance carrier does not cover payment for and any balances that may be due in full
I understand I am responsible for paying deductibles, co-payments, and co-insurance I am aware payment amounts may only be an estimate at the time of service I understand I am responsible for all costs of collecting monies owed (i.e. court fees, attorney fees, and collection agency fees) If payments which I am responsible for are not made in a timely manner (**State Law, Federal Law, and Insurance carrier contracts prohibit any adjusting, writing-off, waiving of copayments or coinsurance, and deductibles)**

I understand I am requesting that my insurance carrier make direct payments to FIX IT PHYSICAL THERAPY for services rendered. If my policy is not in accordance with direct payments to FIX IT PHYSICAL THERAPY, I instruct and approve my insurance carrier to make a check out in **MY NAME: (_____)**and send it to FIX IT PHYSICAL THERAPY facility located on 8262 Griffin road Davie FL, 33328 I also authorize to FIX IT PHYSICAL THERAPY to deposit checks made out to me on my account. I agree any payment made out to me by my insurance carrier will immediately be paid over to FIX IT PHYSICAL THERAPY. _____

(Initials here)

I understand I am assigning FIX IT PHYSICAL THERAPY all rights, claims, benefits, and causes of action for personal injury protection, and any medical payment benefits under the policy affording coverage to me for any and all treatment, services, and medical claims resulting from an automobile accident that occurred on _____/_____/_____. This is to act as an assignment of my rights and benefits to the extent of assignees provided. In the event that I do not have insurance coverage, I understand that I remain personally responsible for payment of services rendered including all costs of collection including attorney fees and costs

Signature:_____Date:_____/_____/_____

CANCELLATION POLICY & NO SHOW POLICY

FIX IT PHYSICAL THERAPY understands there will be times you may have to miss an appointment due to personal reasons, emergencies, and obligations. However, not calling to cancel your appointment you may be preventing the treatment of other patients who are in much need and are trying to schedule an appointment but are not able to due to a "full book" we would like to ask you to please be kind and mindful of others in their time of need and please cancel your appointment.

IF YOU DO NOT CANCEL YOUR APPOINTMENT 24 HOURS PRIOR OR ARE CONSIDERED A "NO SHOW" YOU WILL BE CHARGED $50.00 TO BE PAID AT YOUR NEXT SCHEDULED APPOINTMENT BEFORE ANY SERVICES MAY BE RENDERED TO YOU. YOU ARE PERSONALLY RESPONSIBLE FOR THIS CANCELLATION FEE YOUR INSURANCE CARRIER IS NOT FINANCIALLY RESPONSIBLE FOR THIS FEE.

LATE POLICY

If a patient is 15 minutes past the scheduled appointment time we must cancel and reschedule a new appointment for the patient as we have to keep our doctors and other patients on schedule

SELF-PAY PATIENTS

PATIENTS WHO SELF-PAY MUST MAINTAIN ACCOUNT BALANCES AT ZERO DOLLARS AND MUST BE PAID TO ZERO ($0.00) BEFORE FIX IT PHYSICAL THERAPY MAY RENDER ANY SERVICES TO THEM. IF YOU HAVE QUESTIONS ABOUT BILLING OR PAYMENT PLAN OPTIONS YOU MAY CALL OUR OFFICE AND ASK TO SPEAK TO AN OFFICE REPRESENTATIVE WHICH WILL REVIEW YOUR ACCOUNT.

Signature:_____**Date:**____/____/____