# A HEALTHY APPROACH

**INDIVIDUALIZED PHYSICAL THERAPY SERVICES**
**1800 Tuttle Avenue - Sarasota, FL 34239**
**Phone: 941.953.4202 Fax: 941. 953.4239**

**A HEALTHY APPROACH Individualized Physical Therapy Services** is dedicated to providing you with the best physical therapy you can possibly get. To ensure that you receive a complete and thorough evaluation, **please take a few minutes to fill out this questionnaire.**

**Patient Information:**

Last Name: _____ First Name: _____

Date of Birth: _____ Age: _____ Social Security #: _____

Local Address: _____ City: _____ State: _____ Zip:_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Out of Town Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Email: _____

**Referring Physician:**_____ Phone: _____

Address (if not local): _____

**Emergency Contact:**

Name: _____ Relation: _____

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

Home Phone: _____

**Insurance:** Primary: _____ Secondary:_____

**History of Present Condition:**

Onset Date of Injury or Illness: _____

Average pain level (Scale of 1-10) _____ Is pain constant or intermittent? _____

Symptoms worse in: morning afternoon evening overnight

Sleeping patterns:_____

Any diagnostic tests:_____

Results: _____

Previous treatment for this problem? _____

Have you had physical therapy before? _____ Was the outcome favorable? _____

What would you like to achieve with our therapy? _____

_____

List all major surgeries: _____

_____

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List all medications: _____

_____

Automobile or other accidents: _____

_____

**Functional Limitations:**

| **Please check all that apply:** | Difficult | Unable | Comment |
|---|---|---|---|
| Reach an object on the floor | | | |
| Drive | | | |
| Get in/out of a car | | | |
| Walk for 5 minutes | | | |
| Stand for 5 minutes | | | |
| Vacuuming | | | |
| Mopping/Sweeping | | | |
| Getting dressed | | | |
| Bathing | | | |
| Other | | | |

**Have you ever been diagnosed with any of the following conditions?**
**Please circle all that apply:**

| | | |
|---|---|---|
| Rheumatoid arthritis | Cancer | Poor circulation |
| Other arthritic conditions | Asthma | Hepatitis |
| High blood pressure | Herpes | Depression |
| Emphysema/bronchitis | Anemia | Tuberculosis |
| Epilepsy | Heart disease | Skin problems |
| Multiple sclerosis | Diabetes | Thyroid problems |
| Prostate problems | Chemical dependency (alcoholism) | |

**Have you recently experienced any of the following?**
**Please circle all that apply:**

| | | | |
|---|---|---|---|
| Fatigue | Weakness | Fever/chill | Allergies |
| Poor circulation | Numbness | Blackouts | Dizziness |
| Nausea | Pregnancy | Headaches | Chest pain |
| Jaw pain | Ringing in ears | Weight change | Infection/wounds |
| Shingles | Incontinence | Constipation | Broken bone |

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## Your Rights:

- To receive specific care of your needs provided by qualified staff without regard to race, color, religion, sex, national origin, age, handicap or ability to pay.
- To be treated with respect and dignity.
- Any treatment you have will be fully explained to you. You have the right to refuse treatment, in which case your referring physician will be notified.
- To question the treatment you receive and to obtain a copy of you health record.
- To full explanation of the charges incurred in this facility.

## Your Responsibilities:

- To remain under the care of a physician while receiving therapy related services.
- Provide us with truthful, accurate information regarding health problems, insurance coverage and financial information.
- To participate in your plan of care, cooperate with your therapist and follow instructions given by your therapist.
- **To attend your set appointment with the therapist or notify us of a cancellation at least 24 hours in advance. <u>There will be a $25 cancellation fee for late notice.</u>**

## Notice and Acknowledgement of Privacy Practice:

Your information may be used or shared for **treatment** (when our therapists discuss your care with each other or your physician) and **payment** (when your insurance is billed for services provided to you).

**A HEALTHY APPROACH Individualized Physical Therapy Services** agrees to keep your information private and only use your information as listed above and as the law permits. You will be notified if we make any changes in our privacy practice.

**Complaints:** If you believe your privacy rights have been violated, you may direct your concerns to NTS. You may also submit a complaint to the Department of Health and Human Services. You will not be mistreated for filing a complaint.

Patient or
Responsible Party's Signature:_____ Date:_____

**Please ask if you would like a copy of this notice.**

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## Authorization for Release of Information, Informed Consent and Appointment of Patient's Representative

**I authorize the release** of information from my medical records for the purpose of financial reimbursement to **A HEALTHY APPROACH Individualized Physical Therapy Services** for services rendered. I request that payment be made directly to **A HEALTHY APPROACH Individualized Physical Therapy Services,** I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct, and that this care is subject to Peer review Organization quality review in the event of a written complaint.

**I authorize the release** of my medical records to be reviewed by authorized representatives of Medicare, Medicaid, Blue Cross Blue Shield and/or my private insurance carrier(s).

**I authorize the release** of my medical records to physicians, hospitals, extended care facility or community resources as needed.

**I authorize the staff** of **A HEALTHY APPROACH Individualized Physical Therapy Services** to carry out all procedures as ordered by my physician in the plan of treatment established.

**Authorization of Patient Representative to Medicare:** In the event that my claim for benefit payment is denied, I appoint **A HEALTHY APPROACH Individualized Physical Therapy Services** to act as my representative in connection with my claim under the VXIII Medicare Coverage. I authorize this facility to make or give any request, to present evidence, obtain information and to receive notice in connection with my claim in asserted right wholly in my stead, with no fee incurred.

**I understand that I am responsible** for all charges not covered by my insurance (excluding Workmen's Compensation). I recognize that I am responsible for all co-payments and deductibles, or in the event that I have no insurance coverage or that my employer refuses to pay, I will be responsible for said payment and will make proper reimbursement within thirty (30) days of notification of charges.

I understand that Medicare may pay 80% of these charges after the deductible is met, and co-insurance, if applicable, may pay 20% and the deductible, but if they do not, the balance is my responsibility.

A copy of this assignment has the same effect as the original.

Patient or
Responsible Party's Signature: _____ Date: _____

Witness Signature: _____ Date: _____