739A S. Nova Road
Ormond Beach, Fl. 32174
Phone: 386-671-2626
Fax: 386-671-2627

1402 Dunlawton Ave
Port Orange, Fl, 32127
Phone: 386-671-2626
Fax: 386-671-2627

"Physical Therapy with care and knowledge"

Patient Demographic Information			
Last Name:	First Name:		Middle Initial:
Address:	City:	State:	Zip:
Primary Phone:	Secondary Phone:		
D.O.B:	Social Security:	Driver's License Number:	
May we leave a message? Yes No	Best Time to call: AM PM	Email:	
Employer Information			
Employer:	Address:		
Phone:	May we leave a message?		
Emergency Contact Information			
Name:	Relationship:	Phone:	
Referral Information			
Referring Doctor:			
Primary Care Physician:			
Have you received any physical therapy this year? Yes No			
Are you currently receiving any Home Health Care? Yes No	If yes, what company?		

Authorization/Consent:

I, ____, hereby give consent for treatment for myself, or the named minor child, by the staff at FloRehab Center and/or as directed by my referring physician. I authorize the release of any medical information necessary to process claims for these services. I authorize release of clinical information for treatment, payment and healthcare operations. I assign medical benefits payable for these services directly to FloRehab Center. I understand that I am responsible for payment at the time of service of any applicable co-payments, co-insurance, deductibles, or any self-pay charges if no insurance company or third party is being billed for treatment received.

____ _______________________

Patient/ Legal Guardian Signature *Date*

____ _______________________

Witness *Date*

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Insurance Information

Primary Insurance: ______________________________	**Secondary** Insurance: ____________________________
Name of Policy Holder____________________________	Name of Policy Holder: ___________________________
Policy Holder D.O.B _____________________________	Policy Holder D.O.B ______________________________
Relationship to Patient: ___________________________	Relationship to Patient: ____________________________
Policy Number: _________________________________	Policy Number: __________________________________
Group ID: _____________________________________	Group ID: ______________________________________

Auto/Liability

Insurance Co____

Claim No_________________________________Date of Accident_________________________

Name of Adjuster__________________________Phone No______________________________

Attorney__________________________________Phone No_______________________________

Worker's Compensation

Employer____________________________________Phone No_______________________________

Claim No____________________________________Date of Accident__________________________

Insurance Co_________________________________Phone No__________________Fax No_________________

Financial Policy Statement

I, ____________________________________, authorize the treatment of physical, occupational, and/ or speech therapy services, by FloRehab, Center, LLC. I hereby authorize the release of information for all claim purposes to bill Medicare, Medicaid, or my insurance carrier. Any claim filed is done as a personal courtesy to me by FloRehab Center, therefore I understand that all charges incurred are my financial responsibility.

Patient Agreement

I, ___________________________________, understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by FloRehab Center, LLC. I will be responsible for all costs of collecting monies owed including court costs, collection agency fees and attorney fees.

VERIFICATION OF BENEFITS

Your primary health insurance carrier had verified that you have a $ _________________yearly deductible of which $______________ has been met. Until your deductible has been met, payments will be as follows: $100.00 for the initial evaluation and $60.00 for each office visit. **After** your deductible has been satisfied, your insurance carrier estimates your therapeutic benefits are covered at _____________%. You have an estimated responsibility of $ ____________ or __________% due at each visit.

_______________________________________ ____________________

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Patient Medical History

Patient Name____ Age: ____________ Date: _________________

PRESENT ILLNESS OR INJURY

What is your current problem? ____

How did the present injury occur? __________________ When did this happen? ________________

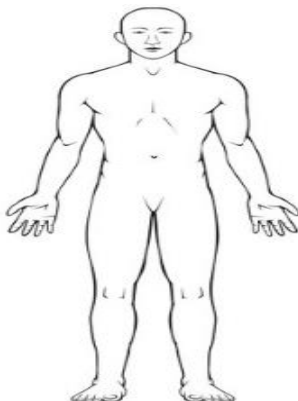
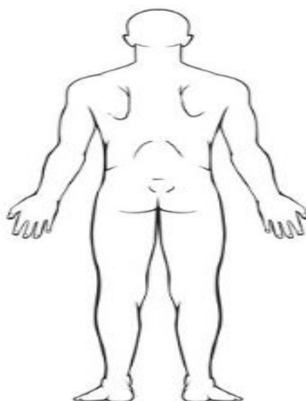
List any previous hospitalizations or surgeries: ____

Have you had any surgery during the past year? ( ) Yes ( ) No What type of surgery?________________

Have you had any previous therapy for this problem? ( ) Yes ( ) No

Have you had any of the following tests done during the past year? ( )CT Scan ( )MRI ( )X-Rays ( )EMG

If you have any pain or discomfort, please mark **where**:

Pain:
( ) Constant
( ) Intermittent

- **Pain Level:** **0 1 2 3 4 5 6 7 8 9 10**
- What aggravates your pain? ____
- How does rest or medication affect your pain? ____
- How does medication affect your pain? ____
- Does your pain stop you from performing any activities? ( ) yes ( ) no What activity? ____________
- What other symptoms do you have (weakness, numbness, less movement, etc.)? ________________

_______________________________________ ____________________

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Please check if you have any of the following:

( ) Diabetes
( ) Heart disease
( ) High blood pressure
( ) Hemophilia
( ) Heart attacks
( ) Pacemaker/Defibrillator
( ) History of cancer
( ) Respiratory illness
( ) Kidney disease
( ) Previous head trauma
( ) Previous back problems
( ) Shoulder dislocation
( ) Arthritis problems
( ) Joint problems
( ) Acute infections
( ) Orthopedic injuries
( ) Spinal Injuries
( ) Special diet restrictions
( ) Hernia
( )CVA or Stroke
( ) Metal Implants
( ) Currently Pregnant
( ) Allergies
( ) Surgery of the head, neck OR spine

Cancellation/No Show Policy

FloRehab Center holds the right of charging the patient a **$25.00** charge for each cancellation **IF** no call/no show to his/her appointment. If you must cancel or reschedule your appointment, please call our office **24 hours** in advance to avoid this fee. The cancellation fee is NOT covered by the insurance and the patient will be responsible for this fee.

Initial: ___________

What to do when you are in pain or Not in pain

A) If you are in pain, **come in** and let us fix what may be causing this to occur
B) If you are not in pain, **now** is the time to progress to the next stage of correcting the underlying causes of your problem as your plan of treatment will be changing as we progress and educate you in how to **not** re-injure yourself, etc.

Initial: ___________

Team Work/Trust

1. **Do NOT cancel or miss your appointments** because that causes a huge delay in achieving our results and goals.
2. Make sure to be **compliant** with your home exercise program that is created **specifically for you** by the Physical Therapist to achieve your goals and results.

_______________________________________ ____________________

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FloRehab center

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New Patient Consent to the Use and Disclosure of Health Information

for Treatment, Payment, or Healthcare Operations

I, ______________________, understand that as part of my health care, **FloRehab Center** originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that **FloRehab Center** is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that **FloRehab Center** reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should **FloRehab** Center change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

____

____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax

I fully understand and accept / decline the terms of this consent.

____ ____________________

Patient/ Legal Guardian Signature *Date*

____ ____________________

Witness *Date*