VENICE PHYSICAL THERAPY
AND SPORTS MEDICINE
1776 S. TAMIAMI TRAIL
SARASOTA, FL 34239

NAME: ______________________________ DATE OF BIRTH: _________ AGE________

ADDRESS:____

____

OUT OF TOWN ADDRESS: _____________________________________

____

PHONE: HOME ( )______________ WORK ( )_______________ CELL ( )________________

PREFERRED WAY TO CONTACT YOU: □ HOME □ WORK □ CELL

EMAIL ADDRESS:_______________________________________

MARITAL STATUS: □ SINGLE □ MARRIED □ WIDOWED □ DIVORCED

REFERRING PHYSICIAN: ______________________________________

PRIMARY CARE PHYSICIAN: ____________________________________

OCCUPATION: ____

LEISURE ACTIVITIES: (INCLUDE EXERCISE ROUTINES): _______________________

____

EMERGENCY CONTACT NAME:_________________________________ PHONE:___________________

RELATIONSHIP:______________________________

IS THE PAIN YOU ARE EXPERIENCING A RESULT OF AN ACCIDENT? □ YES □ NO

IF YES, WHAT TYPE OF ACCIDENT?

□ MOTOR VEHICLE □ WORK RELATED □ OTHER__________________

DATE OF ACCIDENT: ________________

ARE YOU CURRENTLY RECEIVING HOME HEALTH CARE? □ YES □ NO

HAVE YOU HAD PHYSICAL THERAPY THIS YEAR? □ YES □ NO

MEDICATIONS: PLEASE PROVIDE SPECIFIC NAMES AND DOSAGES OF MEDS YOU ARE CURRENTLY TAKING.

(YOU MAY PROVIDE A LIST TO BE COPIED INTO YOUR CHART)

RX: ____

____

____

OVER THE COUNTER: ____

____

ALLERGIES: PLEASE LIST ANY MEDICATION (S) YOU ARE ALLERGIC TO: _______________________

____

CHECK IF YOU CURRENTLY HAVE OR PREVIOUSLY HAD ANY OF THE FOLLOWING:

□ ARTHRITIS □ DIABETES (CIRCLE TYPE) 1 or 2 □ SEIZURES

□ ASTHMA □ HEART PROBLEMS □ STROKE

□ CANCER □ HIGH BLOOD PRESSURE □ ULCERS

□ CIRCULATION PROBLEMS □ PACEMAKER □ OTHER (PLEASE SPECIFY)

____

____

BRIEFLY DESCRIBE WHAT BRINGS YOU TO PHYSICAL THERAPY:

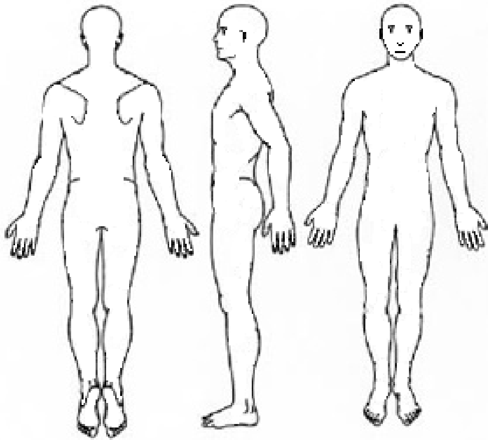
____

____

WHAT DATE (APPROX) DID YOUR PRESENT SYMPTOMS START? ____________

MY SYMPTOMS ARE CURRENTLY: **GETTING BETTER** **GETTING WORSE** **SAME**

BODY CHART: PLEASE MARK THE AREAS WHERE YOU FEEL SYMPTOMS ON THE CHART BELOW.



AGGRAVATING FACTORS:

ACTIVITITES THAT MAKE YOUR SYMPTOMS WORSE:

1.___________________________

2.___________________________

EASING FACTORS

ACTIVITITES THAT MAKE YOUR SYMPTOMS BETTER:

1. ___________________________

2. ___________________________

USING THE 0 TO 10 SCALE, WITH 0 BEING “NO PAIN” AND 10 BEING “WORSE PAIN IMAGINABLE” PLEASE DESCRIBE:

YOUR CURRENT LEVEL OF PAIN WHILE COMPLETING THIS SURVEY: ___________

THE BEST YOUR PAIN HAS BEEN DURING THE PAST 48 HOURS: _______________

THE WORST YOUR PAIN HAS BEEN DURING THE PAST 48 HOURS: _____________

RICK HAUPT PHYSICAL THERAPY

Please read this form completely. By signing the form at the bottom, you indicate that you have read and agree to this form in its entirety.

CONSENT FOR CARE AND TREATMENT

I, THE UNDERSIGNED, DO HEREBY AGREE AND GIVE MY CONSENT FOR Rick Haupt Physical Therapy and its employees to furnish physical therapy care and treatment considered necessary and proper in diagnosing and/or treating my physical condition.

Sign: ___________________________ Date: ________________

(parent or guardian signs if patient is a minor)

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance, or any other health/auto insurance plans to Rick Haupt Physical Therapy. A photocopy of this assignment is to be considered as valid as the original.

I hereby authorize the assignee to release all information necessary (including photocopies of medical records) to secure payments (see HIPPA/" PHI" form). I hereby authorize any Office/Doctor whom I have seen in the past or am currently seeing to release any and all of my medical records and/or diagnostic imaging to Rick Haupt Physical Therapy.

Sign: ____________________________ Date: __________________

(parent or guardian signs if patient is a minor)

RICK HAUPT PHYSICAL THERAPY
Patient Financial Policy

Patients Name: ____

Patient agrees to pay for all services due in full at time services are provided by our office.

Patient Financial Class Policies:
You are required to present a valid insurance card and identification card at every visit as needed throughout your care.

Commercial Insurance Carriers: We bill most insurance carriers for you if proper paperwork is provided to us. Any outstanding balances, co-payments and deductibles are due prior to checking in for your appointments. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated. If an insurance carrier has not paid within 60 days of billing, fees are due and payable in full from you.

Medicare: Our office is a Medicare participating provider and we will bill Medicare for you. We will also bill your secondary insurance for you. Any balance not paid by Medicare and your secondary insurance will be your responsibility. Medicare allows $1,940.00 per calendar year for outpatient physical therapy and speech language therapy combined. Outpatient therapy settings include: private practices, skilled nursing facilities (SNF's), home health agencies, outpatient rehabilitation facilities,
comprehensive outpatient rehabilitation facilities, hospital outpatient departments. If your therapy services go over the $1,940.00 therapy cap, your therapist or doctor can ask for an exception, should they determine that the services continue to be medically necessary. Even if your therapist or doctor asks for an exception, this is not a guarantee that you will not have to pay for costs above the $1,940.00 therapy cap amounts. If Medicare decides, at any time (even after your therapy services have been paid for),
that your therapist or doctor did not show enough proof that your therapy services were medically necessary, you may have to pay for the total cost of the services above the $1,940 therapy cap amount.

Worker's Compensation: If your visit is work- related we will need the case number and carrier name prior to your visit in order To correctly bill your workers compensation insurance carrier.

Auto-Mobile Accidents: If your visit is auto-accident related we will need the case number and carrier name prior to your visit in order to bill the car insurance company. If at any time during your visits at Rick Haupt Physical Therapy you exceed your physical therapy limit set by the car insurance carrier you will be responsible for the remaining balance. At this time, we can bill your primary health
insurance if you would like, but if they do not pay, the balance will be the patient's responsibility.

Methods of payment:
Our office accepts the following payment methods: Cash, Personal Check, Credit Cards

For **returned checks**, we assess a $25.00 NSF charge, and report to the local district attorney's office checks that are not paid within 2 weeks of being returned to our office.
If not paid according to terms the patient understands that our office reports to an outside collection agency. In the event that your account is turned over for collections, patient agrees to pay all additional fees accessed in the collection of debt. These fees include collection agency fees and attorney fees.
The patient is ultimately responsible for all fees for services. I have read, understand and agreed to the above financial policy for payments of professional fees.

Patient sign: ____ Date: ____________________________

PRIVACY STATEMENT

As part of my health care, Rick Haupt Physical Therapy (The Company) creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves and a basis for my continuing care. I understand that this information is used as a means of communicating among The Company's personnel, and with medical personnel outside of this practice. I understand that this information serves as a source of information for applying my diagnosis and surgical information to my bill. I understand that this information is a way for third party insurance companies to assure that a service we bill for was actually performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients. I have been provided an opportunity to review the Notice of Privacy Practices for The Company that provides a more complete review of information uses and disclosures. I understand that I have the right to review this Notice of Privacy Practices before signing this consent.

I understand that The Company may change its Notice of Privacy Practices at any time and that a current copy will be available for my inspection during regular business hours of each medical office.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that The Company is not required to agree to the restrictions requested. The procedure to request restrictions on information use and disclosure is contained in the Notice of Privacy Practices.

I acknowledge that I may request a copy of the Notice of Privacy Practices of Rick Haupt Physical Therapy and agree to the liability limitations explained therein.

____ ____________ ______________________

Signature of Patient Date Relationship to the Patient

____

Printed Name of Patient

RICK HAUPT PHYSICAL THERAPY
2620 S. TAMIAMI TRAIL 3rd Floor
SARASOTA, FL 34239

Attention New and Existing Patients:

Verification of benefits does not guarantee benefit payment from your insurance company.

Well will bill your insurance cards as given as a courtesy to you, our valued patient, however you are the policy holder and are responsible to know your benefits and you will be required to pay ALL Deductibles, Co-pays, and Co-Insurance amounts your Insurance company applies to your account as Insurance claims are processed. If for any reason your Insurance company denies the claim completely you will be responsible for all charges.

If you have a specific question about your benefits, we suggest you contact your Insurance company directly at the number listed on the back of your card.

Thank you in advance for your cooperation that allows us to continue to accept and bill Insurance Companies on behalf of our patients.

NAME: ____

SIGNATURE: ___________________________________

DATE: ____