PATIENT INTAKE FORMS

Patient's Name ____ Date of Birth _________
(last) (first) (middle)

Mailing Address ____
(number and street) (city) (state) (zip)

Home # (___) _________ Cellular # (___) _________ Work # (___) __________

Social Security # _____________________ Employer _____________________________

Email address ___________________________________ Add to Newsletter List? Y N

In Case of Emergency Contact ________________________ Phone # (___) ____________

Referring Physician ____________________________ Date of Injury _________________

Primary Care Physician ____

Would you like us to provide appointment reminders? Y/N Can we leave a message regarding appointment times on your home phone? Y/N work phone Y/N cell phone Y/N

► INSURANCE – PLEASE PROVIDE YOUR CARD- IF CARD IS ON FILE PLEASE SKIP

Primary Insurance Name and Address ____

Subscriber's Name ______________________________ Group # _______________ ID # ________________

Subscriber's DOB: ____________________

Secondary Insurance Name and Address ____

Subscriber's Name ______________________________ Group # _______________ ID # ________________

Subscriber's DOB: ____________________

► Workers Compensation Carrier ◄ ___________________________ Claim # __________________________

For patients under 18 years of age, the parent, relative, or person *escorting* the patient is responsible for any payments due at the time of the service.

Mother's Name _____________________________________ Employer ___________________________

Work # (___) ____________________________ Social Security # _________________________________

Father's Name _____________________________________ Employer ___________________________

Work # (___) ____________________________ Social Security # _________________________________

AUTHORIZATION & CONSENT

- I understand that I am responsible for all charges incurred regardless of insurance or third party liability.
- I authorize contact by the use of my mobile/cell phone number for discussing treatment, confirming appointments and resolution of the balance of my account.
- I authorize Blue Sky Outpatient Therapy to release any medical information necessary to process my claim to my insurance company or to any other concerned third party.
- I understand that I will bear the cost for all associated collections and/or attorney/legal fees if my account is placed with a 3rd party agency and/or attorney for collections or legal action.
- I authorize my insurance company or any other concerned third party to make payment directly to Blue Sky Outpatient Therapy.

____ ____________________

Signature **Date**

Blue Sky Outpatient Therapy Financial Policy & Consent to Treat

This is an agreement between Blue Sky Outpatient Therapy and
____.
(please print name)

In this agreement the words “you,” “your,” and “yours” mean the Patient. The word “account” means the account that has been established in your name to which charges are made and payments credited. The words “we,” “us,” and “our” refer to Blue Sky Outpatient Therapy.

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance/rebilling charge, if any, and any payments or credits applied to your account during the month.

Payment options if you have insurance:

1. If you have a deductible to meet, you choose to pay by ____cash, ____check, or ____credit card at the time services are rendered. We will send your claim to your insurance carrier and will bill you for any additional patient responsibility, if any, which is determined by your carrier.

2. You choose to pay your co-payment, determined by your insurance carrier, by ____cash, ____check, or ____credit card at the time services are rendered. If there is a balance on your account at the end of the month we will bill you accordingly

1. **Payments:** Unless other arrangements are approved, the balance of your statement is due and payable when the statement is issued and is past due if not paid by the end of the month. If extenuating circumstances should arise, you can discuss a payment plan with our Billing Department 330-301-4762 or bjohnson@lincolnrs.com.

<u>CONSENT FOR CARE & TREATMENT</u>

I, the undersigned, do hereby agree and give my consent for Blue Sky Therapy to furnish medical care and treatment to

____that is considered necessary and proper in diagnosing or treating his/her physical and mental condition.

____

Responsible Party Signature & Date

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. It is the insurance company that makes the final determination of your coverage eligibility. Our billing company will verify your benefits with your insurance company and determine if a preauthorization is required.

Non-contracted Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your coverage eligibility. You agree to pay any portion of the charges not covered by insurance.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. We reserve the right to refer your account to an attorney or collection agency. You agree to pay all attorney fees and collection costs incurred in enforcing the terms of this agreement.

Returned Checks: There is a $25 fee for any checks returned by your bank.

Missed Appointments: If you find that you cannot keep your scheduled appointment, we ask that you cancel at least 24 hours in advance. **Failure to cancel with less than 24 hours' notice or "no shows" will result in a cancellation fee of $30.00 per appointment.** This charge must be paid in full before receiving further treatment.

Workers Compensation: We require written approval/authorization by your worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for your payment in full.

Motor Vehicle Accidents: If the insurance policy involved in any motor vehicle accident claim does not accept liability for your claim, you will be held responsible for your payments in full.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's name: ____

Responsible Party: ____
(if not the patient)

Signature: ____

Date: ____

RELEASE OF INFORMATION

Florida GulfCoast Physical Therapy – Powered by Blue Sky Therapy
20451 S Tamiami Trail
Suite 6
Estero, FL 33928
(239) 948-2222 office

Thank you for referring your patient to Blue Sky Outpatient Therapy.

Please forward the medical records regarding this patient so we may provide proper treatment to your patient.

I authorize the release of and correspondence regarding my (or my dependent's) medical records to Blue Sky Outpatient Therapy.

Date ____

Patient Name _________________________________

Date of Birth _________________________________

_____________________________________ ______________

Signature **Date**

HIPAA NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient, and our common practices in dealing with patient health information.

Uses and Disclosure of Health Information:
We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization:
Except as stated below, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring your Authorization:
In the following circumstances, we may disclose your health information without your written authorization:

- For purpose of health and safety
- To Government agencies for purposes of their audits, investigations, and oversight activities
- To Government authorities to prevent child abuse and domestic violence
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders
- When required by court orders, search warrants, subpoenas, and as otherwise required by law

Patient Rights:
As our patient, you have the following rights:

- To have access to and/or copies of your health information
- To receive an account or certain disclosures we have made of your health information
- To request restrictions as to how your health information is used or disclosed
- To request that we communicate with you in confidence.
- To request that we amend your health information
- To receive notice of our privacy practices

Please contact us with any questions, concerns, or complaints regarding our privacy practices.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understand the Notice.

____

Patient Name (please print)

____

Parent or Authorized Representative (if applicable)

_________________________________ _____________

Signature **Date**

PATIENT HISTORY FORM

*Note: This is a confidential record and will be kept in your PT chart. Information contained here will not be released to anyone without your authorization to do so.

Last Name ______________________ First Name ________________________ Middle _________

Today's Date ____ /____ /____   Date of Birth ____ /____ /____

Date of last Physician exam ____ /____ /____

BMI: Height _________ Weight __________

History of Present Problem

Please answer the following questions

What is the main reason for your Physical Therapy evaluation today?
____
____

On a scale of 0-10 (0 is no pain, 10 is worst pain imaginable), circle the number that best describes your average pain?
0 1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?
days ago weeks ago months ago years ago
Other ____________________________

Problem **worsens** with:
Movement Inactivity Standing Lying Sitting
Other ____________________________
____

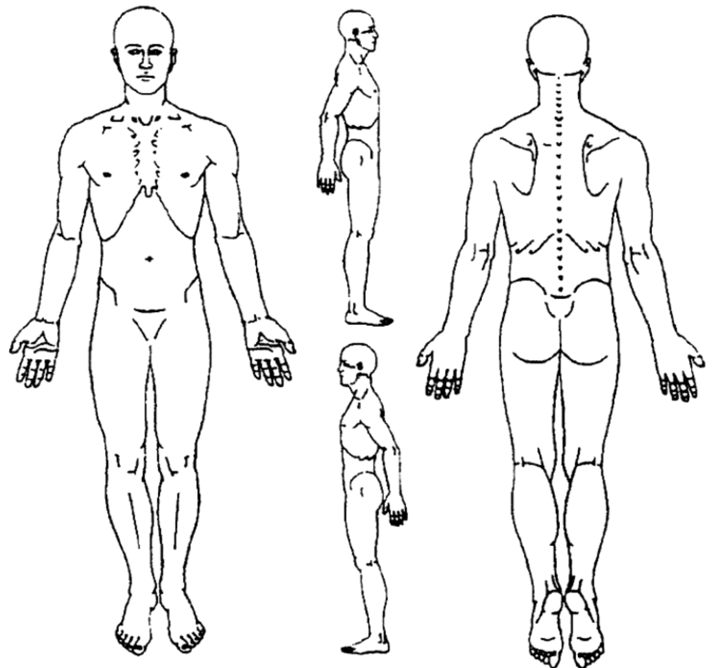
Problem **improves** with:
Movement Inactivity Standing Lying Sitting
Rest Medication Heat Ice
Other ____________________________

How frequently are you bothered by this problem?
Constant Occasional/Variable
Other ____________________________

How would you describe the problem?
Dull Sharp Dull then Sharp Very sharp then leave
Other ____________________________

Do you have any other symptoms?
Yes No If yes, Please explain _________
____

Please mark the location of the pain on the diagram below.



Does the problem interfere with daily functions? No Yes, please explain:

Additional Medical History

Patient Name:____Date:_______________

Please review the following and check if you have a history of:

MEDICAL HISTORY (Do you now or have you ever had):

___Allergies
___Anemia
___Angina
___Anxiety/Panic Disorders
___Arthritis (rheumatoid/osteoarthritis)
___Asthma
___Back Pain (neck pain/low back pain/degenerative disc disease/spinal stenosis)
___Cancer (Type:____________)
___CHF/Any Heart Disease/Heart Murmur
___Chronic Headaches
___Colitis
___Convulsion
___COPD/ARDS/Emphysema
___Crohn's Disease
___Depression
___Diabetes
___Epilepsy/Seizures
___Fractures
___Gastrointestinal Disease (ulcer/hernia/reflux/bowel/liver/gall bladder)
___Goiter
___Headaches
___Hearing Impairment/Hearing Aids
___Heart Attack
___Hepatitis/AIDS/HIV
___High Blood Pressure
___High Cholesterol
___Hypothyroidism
___Incontinence
___Jaundice
___Joint Pain/Swelling
___Kidney/Bladder/Prostate/Urination Problems
___Leukemia
___Multiple Sclerosis/Parkinson's/Any Neurological Disease
___Osteoporosis
___Other Disorders
___Paralysis
___Rheumatic Fever
___Pneumonia
___Previous Accidents
___Prior Surgery
___Prosthesis/Implants
___Psoriasis
___Pulmonary Embolism
___PVD (Peripheral Vascular Disease)
___Sinus Problems
___Sleep Dysfunction
___Stomach or Peptic Ulcer
___Stroke/TIA
___Tuberculosis
___Visual Impairment (cataracts/glaucoma/macular degeneration)

Additional Medical History Continued

Patient Name:_________________________________Date:________________

Do you wear dentures?_____Yes____No

Do you wear glasses/contacts? ______Yes____No

Do you have a pacemaker?_____Yes____No

Do you have any skin allergies? ______Yes____No

Do you have any discomfort/shortness of breath/pain with exercise?_____Yes____No

Do you smoke?____Yes____No

If YES How much do you smoke?_____________When did you quit? _________

If you are a female, Is there a chance that you may be pregnant at this time?___Yes___No

Are you allergic to any medication?____Yes____No_____

If yes, please list:____

List any hospitalizations/reasons/dates:

____

List any medications/dosage you are presently on (If you have a copy of your medications, we would be happy to copy those for you):

____

How did you hear about us?

Doctor Referral___________________ **Event___________________________**

Friend/family recommendation _______ **Repeat Patient (self) ________________**

Prior Patient recommendation ________ **Advertisement ____________________**

Website _________________________ **Phone Book ______________________**

Social Media _____________________

Other (please specify) ____