S O S PHYSIO

Express registration form

Today's Date:

Please Fill-Out Entire Form Completely & Legibly.

1. Patient Info

_____ _____ _____ ❑ Male ❑ Female
Last Name First Name Age

_____ _____ _____ _____
Street Address City State ZIP

(_____)_____ (_____)_____ _____
Home Phone Cellular Email Address (Required in order to receive "News Letters")

_____ _____ (_____)_____
Occupation Employer Name Phone #

_____ (_____)_____ _____
Emergency Contact Person Phone # If Patient is a MINOR: Parent/Guardian Name and Signature Here

Social Security #_____ Date of Birth_____/_____/_____ ❑ Single ❑ Married

Work Status: ❑ Currently Employed: ❑ Retired ❑ Disabled (__Total or __Temporary) ❑ Student (__P/T __F/T)

2. My Condition Info

ALL INFO REQUIRED

My injury/ailment is related to . . .

❑ AUTO/PERSONAL INJURY: Date of accident:_____/_____/_____

❑ WORK INJURY: Complete all information below.

Date of injury: _____/_____/_____

Your company HR person name_____

Insurance adjustor name_____

Insurance adjustor PH#_____

❑ NO INJURY: What do you think may have caused it?

I have already had . . .

❑ SURGERY: When and what type?

❑ PHYSICAL THERAPY BEFORE: When and where?

❑ HOME HEALTH Care: Are you still receiving it?

__YES __NO ❑ OTHER care: What?

3. Payment Info

(Check only one box)

I am paying TODAY by . . .

❑ **INSURANCE** and would like to . . .

__ Get a 25% discount by paying for my treatment plan bill at the time of service or through recurring automated visa payments. I'll get reimbursement on my own. (Ask the front desk person for details)

TREATMENT PLANS

- PHYSICAL THERAPY ..... 75$ (MIN 8)
- PHYSICAL THERAPY + ACUPUNCTURE .....125$ (MIN 8)
- ACUPUNTURE..... ....50$ (MIN 8)

❑ **MEDICARE** . . .

Please provide your Medicare id and supplemental insurance card

❑ **WORKERS COMP** . . .

You must have all info provided under "My Condition..."

❑ **CASH, CHECK, CREDIT** and would like a . . .

__ 25% discount by paying in full for service or through recurring visa automated payments.

❑ I have an **ATTORNEY** and would like to . . .

__ Get a 25% discount by paying up front. I'll get reimbursed after my case settles.

__ Wait until my case settles before paying. I will complete the "Attorney Lien" form. Fees may apply.

4. Referral Info

How did you hear about us?

❑ Friend or Family: ❑ Brochure: Give details:

❑ Internet: ❑ Insurance/Directory:

❑ Advertisement: ❑ Other:

❑ Physician/Dentist/Chiropractor/Nurse: Give details below.

_____
Referring Physician/Person's Name

_____
City State

_____
Phone #

❑ I have read and agree to all the policies on the back of this form. Signature_____

S O S PHYSIO

Important Company Policies for a Successful Relationship

Initial All Boxes

We strive to provide you the best personalized care available. To make this possible we adhere to a set of very important guidelines. Please read them carefully, initial all the boxes, and indicate your agreement by signing on the other side of this form (bottom).

☐ **Late Policy "15-minutes"**
Being late by more than 15 minutes will require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations are unpredictable. We do not allow appointment overlap because this undeservedly compromises the care of another patient.

☐ **24-Hour Advance Notice Fee**
If you wish to change or cancel an appointment we require a minimum ***24-hour advance notice***. Anything less will result in a ***$50 fee*** charged to your account. It costs us money to make appointments available to you. Whether you attend or not we still accrue the expenses (for staff wages, rent, etc.). We don't charge you the actual cost for that appointment but rather a mere ***$50 fee***. We do NOT make money with this charge; it's only to act as a deterrent from making last minute changes. Advance notice allows someone else (who needs it) time to reserve it in place of you. Please be courteous and responsible. Thank you.

☐ **Co pays are due upon arrival or as per treatment plan**
We value and focus on our patient's treatment plans first, therefore would prefer to finalize all finances before hand and focus on your well being. We are set to collect all co pays on the 1ST day of your designated treatment plan or equal preauthorized installments.

☐ **No-shows are bad**
If you fail to show for an appointment without notice all future appointments will be removed and a ***$50 fee*** assessed to your account. You may re-schedule appointments again on a "first come, first serve basis".

☐ **Cell phones must be shut OFF or silent.**
We realize emergencies may arise and therefore allow you to carry your cell phone during your session, how-ever, please be courteous and set to silent mode or turn off. Thank you.

☐ **Children requiring supervision are NOT allowed to attend sessions with you.**
Unless your facility offers child care services, you may not bring children who require supervision with you to your appointment. If your child does not require supervision and is capable of waiting for you quietly then you may bring them. If any disturbance is caused to other patients or staff members you may be asked to terminate your session early and attend to your child.

☐ **Financial Hardship**
If you are experiencing financial difficulties and are unable to afford the cost of our services we have a "Financial Hardship Form" which may be filled-out. If you quality for financial assistance according to the Federal guidelines, we may legally assist you by waiving or discounting your (patient responsibility) portion of the bill. Ask the front desk person for assistance.

☐ **Important Notice from the Federal Government:**
"It is unlawful to routinely avoid paying your co pay, deductible or coinsurance payments . . . even if your doctor allows it. Unless you complete a "Financial Hardship" form and qualify for financial assistance under Federal Standards.

We look forward to building a successful relationship with you that lasts a lifetime!

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ASSIGNMENT OF BENEFITS

1. Benefit Info

What is your deductible amount? $_____ and Coinsurance %_____ (for the services you are seeking) Are there any maximums?

If you don't know this information, call the "800" number on your insurance card. The front desk person may be able assist you.

2. Policy Info

Patient Name:_____ ID #_____ DOB_____

Insurance Policy 1 Name/Number/Group # (if applicable)_____

_____

****IS PATIENT INSURED THROUGH SOMEONE ELSE'S POLICY?*** Give their info here: (otherwise, skip this portion)

- Policyholder Name_____ Date of Birth_____ SSN_____
- Address (if different than Patient)_____
- Relationship to Patient: __ Spouse __ Parent __ Other: _____
- Employer _____ Ph#_____ Claim #_____
- Employer Address _____

Insurance Policy Name/Number/Group # (ifapplicable)_____

I hereby instruct and direct _____ insurance company to **pay by check made out to the "Healthcare Provider" to the right and mail to** the address on the right (not mine). If this current policy prohibits direct payment to doctor/therapist, I hereby also instruct and direct you to make out the check to me and mail it to the above address for the professional or medical insurance policy as payment toward the total charges for the professional services rendered.

Healthcare Provider Info:

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3575 NE 207th Street, Suite B-17
Aventura FL 33180

This is a direct assignment of my rights and benefits under this policy.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

(Check each box and sign at the bottom)

A photocopy of this Assignment shall be considered as effective and valid as the original.

I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.

I authorize the use of this signature on all insurance submissions.

I authorize the "Healthcare Provider" named above to deposit checks made in my name.

I authorize the "Healthcare Provider" named above to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Dated this _____ day of _____, 20_____.

_____ _____ _____

Signature of Policyholder | Witness | Signature of Claimant, if other than Policyholder

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Name: _____Date:_____ Primary Care Physician:_____

Have you RECENTLY noted any of the following (check all that apply)?

- ❑ changes in bowel or bladder function
- ❑ nausea/vomiting
- ❑ dizziness/lightheadedness
- ❑ difficulty maintaining balance while walking
- ❑ weight loss/gain
- ❑ shortness of breath
- ❑ headaches
- ❑ changes in appetite
- ❑ fever/chills/sweats
- ❑ pain at night
- ❑ weakness/fatigue
- ❑ difficulty swallowing

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ cancer (type)_____
- ❑ heart disease
- ❑ high blood pressure
- ❑ asthma
- ❑ pacemaker inserted
- ❑ osteoporosis
- ❑ chemical dependency (i.e., alcoholism)
- ❑ rheumatoid arthritis
- ❑ stroke
- ❑ depression
- ❑ anemia
- ❑ lung problems
- ❑ thyroid problems
- ❑ other_____
- ❑ diabetes
- ❑ multiple sclerosis
- ❑ kidney/liver problems
- ❑ stomach ulcers
- ❑ epilepsy
- ❑ Parkinson's disease
- ❑ other_____

During the past month have you been feeling down, depressed or hopeless? **YES NO**
During the past month have you been bothered by having little interest or pleasure in doing things? **YES NO**
Do you smoke? Yes No _____ pack/day
FOR WOMEN: Are you currently pregnant or think you might be pregnant? **YES NO**

Please list current medications:_____
Are you currently taking blood thinning or anticoagulant medications for any medical conditions? **YES NO**
ALLERGIES: _____ Are you latex sensitive? YES NO

Please list any surgeries or other conditions for which you have been hospitalized, including dates:
1. _____ 2._____ 3._____

Pain at LOWEST: Rate you lowest pain level in past 24 hrs.

0 1 2 3 4 5 6 7 8 9 10
No pain — Worst pain Imaginable

Pain Currently: Rate your level of pain at this time.

0 1 2 3 4 5 6 7 8 9 10
No pain — Worst pain Imaginable

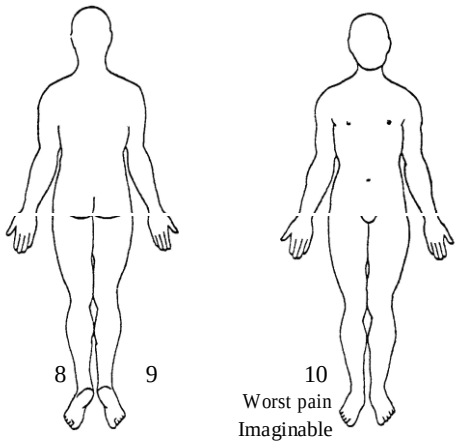
Pain at WORST: Rate your highest pain level in past 24 hrs.

0 1 2 3 4 5 6 7 8 9 10
No pain — Worst pain Imaginable

Body Chart:

Please mark the location of your pain and type of pain on the chart:

Key:
X sharp stabbing pain
O Dull achy pain
….Numb/Tingling
/// Throbbing
== Burning



List 1 (one) important activity you are unable or have difficulty performing as a result of your pain/symptoms. [Circle number below]**:**

_____ (ex. Stairs, reaching overhead) 0 1 2 3 4 5 6 7 8 9 10
No pain — Worst pain

What is your goal for therapy at this time? _____

Patient Signature_____ Date:_____

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Informed Consent and Policies Agreement

Medical Necessity

All treatments must be justified and medically necessary in order for us to treat and bill your insurance. Some of the factors that determine whether or not treatment is medically necessary are:

1) Does your condition interfere with the quality of your life?
2) Does your condition interfere with your ability to perform work or daily activities?
3) Are you motivated and able to participate in your treatment program and follow home and self-care instruction?
4) Is there potential for your condition to improve and/or resolve? If not, is there potential for your function or ability to perform daily activities to improve through modified movement, assistive devices, etc.?
5) Are there specific goals set that are measureable and track-able?

Cancel/No-show/Late

Please refer to the Express Registration Form.

Authorization for Release of Records

Assignment of Benefits (For insurance patients)

Please refer to the Assignment of Benefits form.

Results

The purpose of physical/occupational therapy is to maximize your body's own healing potential through natural means and promote your ability to perform daily, work, and leisure and sports activities through increased strength, flexibility, agility, and movement strategies. It is not possible to predict the results or outcomes of treatment. Sometimes benefits are realized immediately and sometimes it's more gradual over time.

Insurance Patients

It is your responsibility to know your benefit and insurance coverage for physical therapy services, including any maximums or exclusions. You are responsible for all charges whether paid by insurance or not. Any balances that exceed 30 days may incur fees and collection costs.

Medicare Patients

If you do NOT have supplemental insurance, you will be responsible for the twenty percent (20%) co-insurance portion not paid by Medicare as well as any deductible amounts not yet met. It is your responsibility to keep track of therapy cost totals for the purpose of not exceeding the Therapy Cap (unless your diagnosis is exempt from the Cap).

Minors and Parents

If patient is a minor (under 18 years of age), the parent or legal guardian is responsible for all charges and decisions made by the minor. We do not assume any liability for the minor while on premises or not, and it is the responsibility of the parent or guardian to supervise the minor before, during and after treatments.

Informed Consent

By signing below, the patient gives the therapist permission to the evaluation and treatment. It is your right to accept or refuse any treatment offered. There are no guarantees made as to the results that may be obtained from our treatment(s). If you have any questions about your care, be sure to ask the therapist.

It is up to patient/caretaker to inform the therapist/staff about any health problems or allergies patient may have. Patient/caretaker must also tell the therapist/staff about drugs or medications being taken as well as any medical conditions and/or surgeries.

Please discuss any questions or problems with the therapist before signing this statement of understanding and consent for care.

Patient Declaration

The therapist has explained to me the type of treatments ideal for my condition and the benefits of therapy, along with the risk of NOT receiving treatment. I have been given an opportunity to ask questions, and all my questions have been answered to my satisfaction. I confirm that I have read and fully understand this consent and policies form.

I have read and understand the foregoing explanation of rehabilitation/therapy care given to me. I hereby give my consent for the therapist to render treatments to me.

_____
Patient Signature/Date

_____
Patient's Representative Signature/Date

_____
Witness Signature/Date

_____
Relationship to Patient

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Statement of Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

We may disclose your health information to coroners or medical examiners.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

We may contact you by phone, mail, or email. "It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity.

In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by us.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us by calling this office at **(305) 306-8376**. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints about your Privacy rights, or how we have handled your health information should be directed to our Privacy Officer by calling this office at **(305) 306-8376**. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide the company above with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

_____
Patient's Name (print)

_____
Patient's Signature Date

_____
Authorized Facility Signature Date