Thomas Center for Physical Therapy
1717 N. Clyde Morris Blvd., Suite 140 Daytona Beach, Florida 32117
386-257-2672
www.thomasphysicaltherapy.com

Dear ,

Welcome to our practice. We are delighted that you have chosen us for your physical therapy needs. We are a centrally located private practice that specializes in individualized care and hands-on treatment, as well as community educational presentations for health awareness.

We have enclosed information sheets and request that you fill them out and bring them to your appointment on _____/_____/_____. Please arrive at _____, so that we have time to process your paperwork and to make copies of your photo ID and any insurance cards in time for your scheduled appointment with the therapist.

We have also prepared a check off list of reminders to help you arrive at our facility organized:

- ☐ We have reserved the above date and time for your initial evaluation session. Please help us to help you by keeping this appointment and being on time so we can devote the proper time for your evaluation and treatment.
- ☐ Bring in your written referral for therapy from your doctor if you have one. If you do not have a referral, we will send your doctor your Plan of Care to sign off on.
- ☐ When you come for your appointment, please be sure to bring the enclosed paperwork with you, filled out and signed.
- ☐ Remember to wear comfortable clothes or bring pull-on shorts; a T-shirt; no jeans please.
- ☐ Don't forget to bring your Photo ID, Insurance Cards, and your calendar to schedule appointments for therapy.
- ☐ We collect at time of service and can take cash, credit card, or check for payment.

We are looking forward to meeting you. Please drive safely to your appointment.

Enclosures

PATIENT INFORMATION FORM

NAME_____ **PARENT/GUARDIAN** _____
(If patient is a minor)

ADDRESS_____

CITY/ZIP CODE _____ **WORK PHONE**_____ **EXT**_____

HOME PHONE _____ **CELL PHONE** _____

E-MAIL ADDRESS _____
(Please - print clearly)

SOCIAL SECURITY #_____ **DATE OF BIRTH** _____

SPOUSES'S NAME _____ **SPOUSES'S WORK PHONE** _____

WHO SHOULD WE CONTACT IN CASE EMERGENCY _____ **PHONE** _____

PRIMARY CARE PHYSICIAN_____ **PHONE**_____

PLEASE LIST THE CONCERNS YOU HAVE THAT BRING YOU TO OUR OFFICE TODAY: _____

_____ _____ _____ _____

WHO MAY WE THANK FOR REFERRING YOU TO US? _____

* *

- **I authorize treatment for me (or my minor child) from Thomas Center for Physical Therapy.**
- **I understand and agree that I am responsible for any charges incurred for any professional services rendered.**
- **I understand that I am responsible for any supplies and/or taping costs at the time they are dispensed.**
- **We respectfully request that you cancel any appointments 24 hours in advance. It is our policy to charge a fee of $90.00 for appointments that are not canceled with this notice. I have read this and understand.**
- **I certify this information is true and correct to the best of my knowledge.**
- **I will notify you of any changes in my health status or the above information.**
- **I have read and understand the notice regarding health care privacy practices.**
- **My signature gives permission to submit insurance, if applicable.**
- **I authorize that any photos, slides, or films of myself (or my minor child) may be used for teaching purposes, marketing purposes or educational presentations by Thomas Center for Physical Therapy.**

_____ _____/_____/_____
Patient's Signature **Date**

OFFICE USE ONLY: _____

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and/or disclosed, and how you can obtain access to this information. Please review the following information carefully:

1) We may use your information to remind you of appointments.
   How would you like your appointment reminders to arrive:

   PLEASE CHOOSE ONE
   ☐ via text ☐ via e-mail

   _____ _____
   Phone number E-mail address

2) We may use your information to discuss your progress with your doctor or other health care professionals.

3) We may use your information to recommend alternative health care treatments.

4) We may use this information to obtain referrals for your continued health care.

5) We will *not* give this information to any family member or attorney without your express written permission.

   I give permission for my medical records to be discussed with the following person:

   _____ _____
   Relationship

We reserve the right to change our privacy practices and apply revised privacy practices to protect health information. If you would like additional information regarding any of the above matters, please contact our office. If you believe there has been a violation of your privacy rights within our entity, contact Dr. Megan Kearney at the phone number listed below.

_____ _____
Signature Date

Patient Appointment Policy

What happens when you cancel your appointment with less than 24 hours' notice?

We reserve your appointment time to help you accomplish your goals, if you don't show up, you can't get better. When appointments are missed, it has also then prevented another patient, (in need of receiving the same care who could have been seen at that time), from being treated.

When it comes to no-shows and cancellations, we have a strict policy.

You will need to call in *no later than the day before* your appointment if you need to cancel.

Less than 24 hours' notice for a cancellation:

First instance: you will receive a verbal reminder of the policy.
Second instance: you will incur a $90.00 late cancellation fee charge.

<u>In the Office</u>

Schedule an appointment by calling 386.257.2672

Walk-ins will be accommodated after a scheduled patient.

Patients who arrive on time are seen at their appointment time. If you arrive late, (15 minutes or more) we may need to abbreviate or reschedule your visit. If we can see you that day, you may also be charged a late fee of $35.00.

Call ahead if you are going to be late or unable to make your appointment time. We will do all that we can to accommodate your appointment and to minimize the need to reschedule your appointment.

Thomas Center for Physical Therapy will charge the patient a $90.00 No-Show Fee for not showing for scheduled appointments or cancelling on same day. No new appointments will be scheduled prior to the No-show or Late fees being paid.

I have read the above policy and understand, and I agree to be charged and will pay a $90.00 No-Show Fee per appointment that is missed, or the $35.00 Late Fee.

_____ _____

Signed Date

NAME: _____ **DATE:** _____/_____/_____

MEDICATIONS:

NAME of MEDICATION	DOSAGE (mg/IM)	HOW/WHEN TAKEN (oral/injection)

VITAMINS and/or SUPPLEMENTS:

NAME	DOSAGE (mg/IM)	HOW/WHEN TAKEN (oral/injection)

PATIENT NAME: _____ **DATE:** _____/_____/_____

Please check the appropriate answers below (yes or no) regarding your medical history.
Feel free to include additional comments on any medical condition.

Health History

General Health

	Yes	No	Comments
Cancer	_____	_____	_____
Diabetes mellitus	_____	_____	_____
Frequent colds/flu	_____	_____	_____
Insomnia (inability to sleep)	_____	_____	_____
Malaise (discomfort/uneasiness)	_____	_____	_____
Migraines	_____	_____	_____
Night pain/sweats	_____	_____	_____
Numbness/tingling	_____	_____	_____
Seizures	_____	_____	_____
Syncope (fainting)	_____	_____	_____
Thyroid problems (low or high)	_____	_____	_____
Unexplained weight change	_____	_____	_____
Vertigo (dizziness)	_____	_____	_____
Frequent or near falls	_____	_____	_____
Balance concerns	_____	_____	_____

Musculoskeletal System

	Yes	No	Comments
Arthritis	_____	_____	_____
Fractures	_____	_____	_____
Frequent pains	_____	_____	_____
Frequent sprains/strains	_____	_____	_____
Muscle spasms	_____	_____	_____
Stiffness	_____	_____	_____
Weakness	_____	_____	_____

Pulmonary System

	Yes	No	Comments
Allergies	_____	_____	_____
Asthma	_____	_____	_____
Cough	_____	_____	_____
Dyspnea (difficulty breathing)	_____	_____	_____
Emphysema, pneumonia	_____	_____	_____
History of smoking	_____	_____	_____
Sputum - amount/color	_____	_____	_____
Wheezing (whistling sounds with breathing)	_____	_____	_____

Health History(continued):

NAME: _____ **DATE:** _____/_____/_____

Cardiovascular System

	Yes	No	Comments
Abnormal EKG	_____	_____	_____
Angina (chest pain)	_____	_____	_____
Claudication (calf pain with walking)	_____	_____	_____
CVA (stroke)			
TIA (transient ischemic attack)	_____	_____	_____
(Constriction of blood vessels)			
Hypercholesterolemia			
(High cholesterol)	_____	_____	_____
Hypertension (high blood pressure)	_____	_____	_____
Orthopnea (breathing discomfort in positions other			
than erect, sitting or standing)	_____	_____	_____
Palpitations (rapid heart throbbing)	_____	_____	_____
Swelling of extremities	_____	_____	_____

MEDICAL CONDITIONS:

_____

_____

_____

SURGERIES and DATES:

_____

_____

_____

_____

LIST THE EXERCISES YOU PERFORM PRESENTLY:

_____

_____

_____

POLICY REGARDING MEDICARE COVERAGE:

Reaching for Excellence is our commitment to you. We want your experience with Thomas Center for Physical Therapy to be a positive one in all aspects of our clinic. Your clear understanding of our financial policy regarding Medicare coverage is important to our professional relationship. Please feel free to ask questions at any time and we will be happy to work with you.

We do not accept assignment on any Medicare or private insurances. Which means we collect at time of service and that the patient is then responsible to submit their bill to their insurance for reimbursement if they choose to do so. Because that process can be daunting; as a courtesy, on your behalf, we offer to submit that bill to your insurance for you.

Understanding your charges; for our Medicare patients:
We use the fee schedule provided by Medicare for "Limiting Charge". A limiting charge is an upper limit on how much doctors who do not accept Medicare's approved "reduced rate" amount as payment in full can charge to people with Medicare. Federal law sets the limit at 15 percent more than the Medicare "reduced rate" approved amount. Non-participating providers can charge up to 15% more than Medicare's approved amount for the cost of services you receive (known as the limiting charge). This means you are responsible for up to 35% (20% coinsurance + 15% limiting charge) of Medicare's approved amount for covered services.

For further information please go to:

https://www.medicare.gov/your-medicare-costs/part-a-costs/lower-costs-with-assignment

We ask that you make payment to us in full at the end of each visit and Medicare will send any reimbursement you are entitled to, directly to you.

Medicare will not pay for any supplies that may be used during your treatment or taken home with you. Payment for these supplies will be your responsibility.

Medicare (Part B) requires you to have an updated referral every ninety (90) days during the course of your physical therapy treatment in order for you to be reimbursed. Failure to obtain a new referral or signed plan of care from your doctor will result in Medicare rejecting your claims and financial responsibility will fall to you.

We will not be responsible for any discrepancies or misinformation given to us by Medicare regarding your coverage. We *will not* become involved in disputes between you and Medicare regarding deductibles, co-payments, covered charges, usual and customary fees, etc., other than to supply factual information regarding your treatment.

We thank you in advance for your cooperation regarding this sensitive matter.

PATIENT NAME: _____
(Please print)

_____ _____/_____/_____
PATIENT SIGNATURE DATE