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 Orthopedic & Sports 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 may be used for teaching purposes, educational presentations or as part of the marketing brochures by Thomas Orthopedic & Sports Physical Therapy.**

_____ _____/_____/_____

Patient's Signature **Date**

OFFICE USE ONLY: _____

PATIENT NAME: _____ **AGE:**_____ **SEX:** _____
DATE: _____/_____/_____

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

REVIEW OF SYSTEMS CHECK LIST

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)	_____	_____	_____

REVIEW OF SYSTEMS CHECK LIST (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:

_____

_____

_____

Thomas Orthopedic & Sports Physical Therapy 100 Professional Boulevard Daytona Beach, FL 32114
(386) 257-2672 www.thomasphysicaltherapy.com

REVIEW OF SYSTEMS CHECK LIST (continued): **NAME:** _____
DATE: _____/_____/_____

MEDICATIONS:

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

VITAMINS and/or SUPPLEMENTS:

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

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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 phone call ☐ via text ☐ via e-mail

   _____ _____ _____
   Phone number 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 either Sarah Thomas or Randy Thomas at the phone number listed below.

_____ _____
Signature Date

100 Professional Blvd
Daytona Beach, FL 32114
Ph: (386)257-2672 | Fax: (386) 252-1005 | Email: info@thomasphysicaltherapy.com

MEDICARE PATIENTS

REFERRAL POLICY ACCORDING TO MEDICARE:

In order to receive reimbursement for physical therapy treatment, you are responsible for obtaining and presenting to us an up-to-date referral from a medical doctor.

Medicare patients are required to obtain an updated referral every ninety days (90) to ensure Medicare reimbursement.

We will provide you with a current progress report to present to the doctor for his records and to generate an updated referral.

Medicare will not reimburse you for your visit without the current referral.

_____ _____/_____/_____

PATIENT NAME (please print) **DATE**

_____

PATIENT SIGNATURE

PATIENT NAME: _____
(please print)

Please read the following office policy, then sign (and date) on the signature line provided.

POLICY REGARDING MEDICARE COVERAGE:

Reaching for Excellence is our commitment to you. We want your experience with Thomas Orthopedic & Sports 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 will submit your Medicare claim; however, we *do not* accept assignment from Medicare. We ask that you make payment to us in full at the end of each week and Medicare will send reimbursement directly to you. However, if you have extenuating circumstances and wish to discuss them, please feel free to speak with our Financial Coordinator. We at Thomas Orthopedic & Sports Physical therapy are more than happy to address your particular situation and help you with ***Reaching for Excellence*** regarding your health.

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 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 SIGNATURE DATE