STARACE TOTAL BALANCE
PHYSICAL THERAPY P.A.

Patient Information

Please Print

Claim Type: (check one) ☐ Workers' Compensation ☐ Health Insurance ☐ Self-Pay ☐ Personal Injury/Attorney

PATIENT DEMOGRAPHICS

First Name | Middle Name | Last Name | Suffix | Social Security Number | Date of Birth | ☐ Male ☐ Female

Mailing Address | Apt. # | City | State | Zip

Home Phone Number | Cell Phone Number | Email Address | Language | ☐ Single ☐ Married

Have you been treated at Starace Total Balance PT before? ☐ Yes ☐ No

How did you hear about us? ☐ Radio ☐ TV ☐ Friend ☐ Referral ☐ Phone Book ☐ Internet ☐ Sign ☐ Other

EMERGENCY CONTACT: Name | Relationship | Phone Number | Address

RESPONSIBLE PARTY: Name | Social Security Number | Address

INJURY DETAILS

Type of Injury | Date of Injury

EMPLOYMENT INFORMATION

Employer Name | Occupation | Employment Status

Employment Contact Name | Phone Number | Address

Has a claim been filed to the workers' compensation carrier? ☐ Yes ☐ No

MEDICAL INSURANCE INFORMATION (Please present your insurance card and ID with this form)

PRIMARY INSURANCE

Insurance Company Name | Policy Number | Group Number | Are you the policyholder? ☐ Yes ☐ No*

*COMPLETE THIS BOX IF YOU ARE NOT THE POLICY HOLDER FOR YOUR PRIMARY INSURANCE

Policy Holder's Name | Date of Birth | Social Security Number | Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy Holder's Address | Policy Holder's Employer

SECONDARY INSURANCE

Insurance Company Name | Policy Number | Group Number | Are you the policyholder? ☐ Yes ☐ No*

*COMPLETE THIS BOX IF YOU ARE NOT THE POLICY HOLDER FOR YOUR SECONDARY INSURANCE

Policy Holder's Name | Date of Birth | Social Security Number | Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy Holder's Address | Policy Holder's Employer

Do you have Medicare? ☐ Yes ☐ No (If yes, please give a copy of your card to the front desk.)

AUTHORIZATION

By my signature below, I hereby authorize the release of medical information needed to process my claim through my insurance company. I authorize my insurance benefits to be paid directly to Starace Total Balance Physical Therapy P.A. that I am financially responsible for any amounts not covered and/or paid by them. It is the policy of this office to collect charges for services as they are rendered, unless prior arrangements are made and credit is established. Insurance patients are responsible for paying their co-payments and deductible at the time services are rendered.

I hereby authorize such treatment as is necessary and to perform medical treatment on the basis of findings during the course of said treatment. I hereby certify that I have read and fully understand the above authorization for treatment, the reason the above named treatment is considered necessary the advantages and possible complications, if any, as well as possible alternative modes of treatment which were explained to me. I also certify that no guarantee or assurance had been made as to the results that may be obtained.

X

Patient or Responsible Party's Signature | Date

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Medical History

INJURY DETAILS

Type of Injury: _____ Date of Onset: _____

How did the injury occur? _____

List any medications you are presently taking (if any): _____

Have you had x-rays taken for this injury? ☐ Yes ☐ No

PAIN DESCRIPTION

Which of the following best describes your pain? (check one) ☐ Sharp ☐ Dull ☐ Aching ☐ Shooting

Which of the following best describes the frequency of your pain? (check one) ☐ Constant ☐ Intermittent ☐ Occasional

What makes your pain feel worse? (check all that apply) ☐ Lifting ☐ Leaning ☐ Dressing ☐ Climbing ☐ Sitting ☐ Walking ☐ Standing ☐ Reaching ☐ Driving ☐ Bending ☐ Stooping ☐ Laying Down

What makes your pain feel better? _____

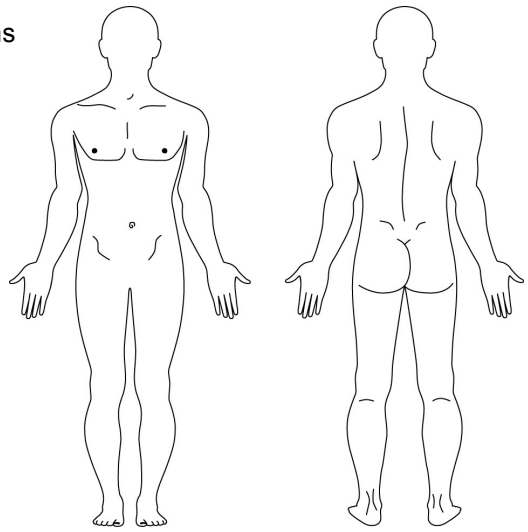
Please rate the level of pain you have experienced over the past 30 days:	NO PAIN 0	1	2	3	4	MODERATE PAIN 5	6	7	8	9	WORST PAIN 10
What number on the pain scale best describes your pain **right now**?	○	○	○	○	○	○	○	○	○	○	○
What number on the pain scale describes your **worst pain** over the past 30 days?	○	○	○	○	○	○	○	○	○	○	○
What number on the pain scale describes your **least pain** over the past 30 days?	○	○	○	○	○	○	○	○	○	○	○

SYMPTOM DIAGRAM

Using the diagram at right, please indicate the location and type of symptoms you are experiencing.

(Use the symbols from the diagram key to indicate the location and type of symptom on the image.)

DIAGRAM KEY	
SYMBOL	SYMPTOM
X	pain
. . . . .	numbness
_ _ _ _	tingling



GENERAL MEDICAL HISTORY

Do you have a history of cancer?..... ☐ Yes ☐ No

Do you have a pacemaker? ..... ☐ Yes ☐ No

Do you have hypertension?..... ☐ Yes ☐ No

Do you have bowel/bladder problems?..... ☐ Yes ☐ No

Are you diabetic?..... ☐ Yes ☐ No

Are you pregnant? ..... ☐ Yes ☐ No

Please list any other relevant past medical or orthopedic history: _____

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MEDICATION LIST

PATIENT NAME: **DATE**

LIST ALL THE PRESCRIPTION MEDICATIONS YOU ARE CURRENTLY TAKING			
NAME OF THE MEDICATION	**DOSAGE** (How many or how much you take.)	**FREQUENCY** (How often you take it.)	**ROUTE** (How you take it, i.e., by mouth, injection etc.)
LIST ALL OVER-THE-COUNTER MEDICATIONS YOU ARE CURRENTLY TAKING			
NAME OF THE MEDICATION	**DOSAGE**	**FREQUENCY**	**ROUTE**
LIST ALL HERBALS, VITAMINS, MINERALS, NUTRITIONAL SUPPLEMENTS YOU ARE CURRENTLY TAKING			
NAME OF THE MEDICATION	**DOSAGE**	**FREQUENCY**	**ROUTE**

Patient Appointment Policy

No-shows and cancellations with less than **24 hours (one weekday)** notice are a significant problem for our small practice. Many practices intentionally overbook appointments to offset missed visits, which can increase wait times for all patients. To help maintain timely access to care, Starace Total Balance Physical Therapy has adopted the following policy.

Our Policy
• We enforce a strict appointment policy.
• A $50.00 No Show Fee will be charged for missed appointments without proper notice.
• We do not routinely overbook appointments.

Office Guidelines
• Schedule appointments by calling **(386) 385-8749**.
• Walk-in patients will be accommodated after scheduled patients.
• Patients arriving late may have their appointment abbreviated or rescheduled.
• Please call ahead if you will be late or unable to attend your appointment.
• Please turn off cell phones while in the office and exam rooms.

Policy Violations
Patients may be dismissed from the practice for:
• Missing any two scheduled appointments.
• Canceling appointments with less than 24 hours (one weekday) notice.

Patients who do not call or leave a voicemail at least **24 hours in advance** to cancel a scheduled physical therapy session will be charged a **$50.00 No Show Fee**. By signing below, you authorize Starace Total Balance Physical Therapy, P.A. to charge the credit card on file when proper notice is not provided.

Patient Acknowledgment
I have read and understand this appointment policy. I understand that I may be dismissed as a patient for missing any two scheduled appointments. I also authorize Starace Total Balance Physical Therapy, P.A. to charge the credit card on file a **$50.00 No Show Fee** for appointments canceled without at least 24 hours (one weekday) notice or for missed appointments.

Patient Signature: _____	Date: _____
Printed Name: _____	
Credit Card Number: _____	Exp: _____
Security Code (CVV): _____	

CONSENT FOR TREATMENT: I understand I have the right to choose my physical therapy provider and have chosen *Starace Total Balance Physical Therapy P.A.* and hereby authorize and give my consent for physical therapy care deemed necessary or advisable in evaluating or treating my physical condition. I further understand no guarantees have been made to me as to the outcome of treatment.

Initial ___

CONSENT FOR TREATMENT OF A MINOR: As parent and/or legal guardian, I authorize and give my consent for

Advance Therapy to treat_____(minor's name). **Initial** ___

PRIVACY NOTICE and RELEASE OF MEDICAL INFORMATION: A Notice of Privacy Practices (NPP) is available for your review or you may take it with you. The NPP describes our comprehensive efforts to protect the privacy of your personal health and financial information. The NPP also describes how much information may be used, released or shared under the Health Insurance Portability and Accountability Act (HIPAA). **Initial**___

CONSENT TO CONFIDENTIAL MEDICAL INFORMATION

I hear-by authorize *Starace Total Balance Physical Therapy P.A.* to share any and all of my medical / billing information with the following people:

Full Name:_____Relationship: _____

Full Name:_____Relationship: _____

FINANCIAL POLICY: As a courtesy, we will verify your insurance benefits; however, it is ultimately your responsibility to be aware of your specific coverage. We will also bill your insurer on your behalf. If your insurer designates that a copayment, deductible, and/or co-insurance is your responsibility, we are obligated to collect it. The ultimate payment responsibility is yours – you will be billed for any balance not paid by your insurance. **Initial**___

ATTENDANCE, CANCELLATION, and NO SHOW: Attendance at your therapy visits is your most important responsibility because it can make the difference between whether you succeed in your treatment or not. While we understand you may need to cancel an appointment because of unforeseen circumstances, we do require at least a 24 hour notice of cancellation so that we can put another patient in your time slot. The fee for a late cancellation or missed appointment is $50.00, which is the patient's responsibility. Documentation of missed appointments may be forwarded to your physician or case manager, which may jeopardize your claim. We reserve the right to discontinue treatment for non-compliance with your physical therapy program.

Initial ___

I certify that any and all information provided by me in furtherance of my application for health care benefits are true. It has been fully explained to me and all of my questions about the form have been answered. I understand its contents.

Patient Signature:_____**Date:**_____/___/___

Staff Witness Initials: _____

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____