Patient Name:

PATIENT INFORMATION				
Patient's Name First:	M.I.:	Last:		
Address:	City:		State:	Zip:
Home Phone:	Cell Phone:	Email:		
Preferred Method of Appt Reminders:[ ] Home Phone [ ] Cell Phone [ ] Text [ ] E-mail [ ] Check here for No Appt Reminder				
Date of Birth:	Gender:			
Date of Injury:	Place (State) of Injury:			
Emergency Contact:	Relationship:	Phone:		
Social Security Number: (for Workers Comp)				

PATIENT INSURANCE INFORMATION – PLEASE BRING YOUR INSURANCE CARD			
Primary Insurance Company:	ID#:	Group#:	
Name of Subscriber:	Date of Birth:		
Relationship to Subscriber: (Circle One) Self / Spouse / Minor / Other	Gender:		
Employer:	Work Phone:		
Secondary Insurance Company (If Applicable):	ID#:	Group#:	
Name of Subscriber:	Date of Birth:		
Relationship to Subscriber: (Circle One) Self / Spouse / Minor / Other	Gender:		

GUARDIAN INFORMATION (IF UNDER 18 YEARS OLD)			
Name Last:	First:	M.I.:	SSN:
Address:	City:	State:	Zip:
Employer:	Work Phone:		

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA)

I acknowledge that I have been provided and have read a copy of my rights and responsibilities as a patient of Back to Work Physical Therapy according to the Health Insurance Portability and Accountability Act (HIPPA), and have been provided information on how to file a complaint should I desire to do so.

CONSENT FOR TREATMENT

Consent for Treatment: I understand I have the right to choose my physical therapy provider and have chosen Back To Work Physical Therapy and hereby authorize and give my consent for BTWPT to furnish physical therapy care and treatment 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 treatment. I understand that I may refuse treatment or terminate services at any time and the agency may terminate their services to me at any time.

Consent for Treatment of a Minor: As parent and/or legal guardian, I authorized and give my consent for Back To Work Physical Therapy to treat_____(minor's name) while I am not present.

Patient / Guardian / Responsible Party Signature:		**Date:**

Patient Name:

OFFICE POLICY AND FINANCIAL RESPONSIBILITY

PATIENT INFORMED CONSENT: I have read and fully understand Back To Work Physical Therapy's Notice of Information Practices. I understand that BTWPT may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations by notifying the practice. I also understand that Back To Work Physical Therapy will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Back To Work Physical Therapy's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time. **_____Initials**

ATTENDANCE, CANCELLATION, and NO SHOW: Attendance at your therapy visits is your most important responsibility because it can make the difference between whether or not you succeed in your treatment. While we understand you may need to cancel an appointment because of unforseen circumstances, we do require at least 24 hours-notice of cancellation. There is a $45 charge for cancellation without prior notice or for not showing for your appointment. This charge is not covered by insurance, and you are required to pay this fee personally. **_____Initials**

FINANCIAL RESPONSIBILITY: As a courtesy to you, Back To Work Physical Therapy will file your medical insurance claims. The contract between you as a patient and your insurance company is, however, personal to you. BTWPT is not responsible for issues between the patient and insurance carrier, nor can BTWPT intervene or negotiate for either party on disputed claims. Please advise us immediately if you change insurance coverage while undergoing treatment. Physical therapy equipment and/or supplies are typically not reimbursable by the insurance carrier. As such, BTWPT requires payment by the patient for any equipment/supply at the time the order is placed. BTWPT will provide a receipt as documentation of the purchase so you may pursue reimbursement personally. BTWPT accepts Cash, Visa, Mastercard, or Discover as payment options. **_____Initials**

CONSENT TO CONFIDENTIAL MEDICAL INFORMATION – MEDICAL RECORDS RELEASE

I hereby authorize Back To Work Physical Therapy to share any and all of my medical / billing information with the following people:

Full Name:_____Relationship_____

Full Name:_____Relationship_____

PATIENT AUTHORIZATION

_____By my initials and signature I understand these policies and my financial obligations for services rendered.

_____I hereby authorize and assign payment of benefits by my insurance company to Back To Work Physical Therapy, and I accept responsibility to ensure my insurance carrier makes payment on my account within 90 days. Lack of payment by my insurance carrier will result in all charges being transferred to my personal balance on my statement.

_____I hereby agree to pay any office visit/co-payment charges at the time of my visit.

_____I hereby agree to promptly pay my personal account balance including co-insurance or unmet deductible upon receipt of my statement. I understand and agree that responsibility for payment of services rendered is mine, due and payable unless other financial arrangements have been made. In the event of default, I agree to pay such collection costs and reasonable attorney fees as may be required to effectively collect the debt.

Patient Signature:_____Date:_____

Parent / Guardian / Guarantor:_____Date:_____

Patient Name:

BACK TO WORK PHYSICAL THERAPY FINANCIAL POLICY

Patient:	ID#:	Group#:
Primary Insurance:	Effective Date:	Spoke to:
Authorized for:	Pre-cert Instructions:	Reference#

As courtesy to you, we have verified your insurance coverage and benefits as of _____. This information is being provided to you exactly as it was told to us. Please be aware that your benefits and/or coverage information may be subject to errors and that verbal verification of benefits is not a guarantee of payment: The WRITTEN terms of your health insurance policy are the basis for benefit decisions. **WE STRONGLY ADVISE THAT YOU CONTACT YOUR HEALTH AND/OR AUTO INSURANCE COMPANY TO VERIFY THIS INFORMATION YOURSELF.** Back to Work Physical Therapy will not accept financial responsibility for misleading or incorrect information given to us by your health insurance company.

Also, it is your responsibility as a patient to keep track of the physical therapy limitations of your health and/or auto insurance policy. Please note that limitations for physical therapy are often combined with, but not limited to; occupational therapy, speech therapy, cardiac rehabilitation, chiropractic services, and acupuncture services. You are financially responsible for any services rendered here after you have exceeded your therapy limitations.

Deductibles: Some health and auto insurance policies subject physical therapy treatment to a deductible. If this applies to you, please note that deductibles reset to their full amount on a specific date each year, typically January 1st. You are financially responsible for any deductible on your policy. Health insurance coverage for physical therapy services will not be available until you have satisfied your deductible.

I understand that if Back to Work Physical Therapy is not contracted as an "In-Network Provider" with my health and/or auto insurance policy, payment may be forwarded directly to me. I agree to forward payment or will personally issue payments for these services to Back to Work Physical Therapy. I understand that denial of payment or reduction of rates by my health insurance company due to any of the following or any combination of the following: over-utilization, usual and customary, failure to pre-certify, contract limitations, non-covered services, exhaustion of benefits, etc., does NOT relieve my personal financial obligation for services rendered at Back to Work Physical Therapy. I agree to pay any outstanding sum I may have at this facility.

Please INITIAL Highlighted Benefits related to your policy.

_____You do not have a co-pay associated with your primary insurance.

_____You do not have a deductible associated with your primary insurance.

_____You do not have a co-insurance associated with your primary insurance.

_____You have a secondary insurance with _____. Your benefits are as follows:
_____.

_____I authorize Back To Work Physical Therapy to keep my credit card (MASTERCARD, VISA, AMERICAN EXPRESS, or DISCOVER) on file in an encrypted form, for the purpose of paying my copay, co-insurance, or deductible at each visit. I understand I will be provided a copy of my receipt upon my request.

If there are concerns regarding your financial responsibility for this service, please ask at our Front Office for clarification.
By signing below, you are stating that you fully understand and acknowledge the above-mentioned information regarding eligibility and benefits, and that you agree to take full financial responsibility for all services rendered at Back to Work Physical Therapy.

CONSENT: I understand these benefits as explained to me.		
Patient or Legal Guardian Signature:		Date:
BTWPT Employee Signature:		Date:

Patient Name:

MEDICAL HISTORY

Have you had a physical exam in the past year? (circle) Yes / No

What is your Diagnosis/reason for coming to therapy?

Who referred you to us? / How did you hear about us?

Full Name of your Primary Care Physician:

Full Name of your Referring Physician:

Have you had any of the following conditions? If yes, please give appropriate date of onset.

	No	Yes	Date		No	Yes	Date		No	Yes	Date
Heart Trouble				Epilepsy				Diabetes			
High Blood Pressure				Stroke/CVA				Fracture			
Bleeding Disorder				Asthma				Cancer			
Headaches				Emphysema				Pacemaker			
Bladder/Bowel				Back Injury				Dizzy Spell			
Fainting Spells				Arthritis				Hepatitis			
Osteoporosis/penia				Depression				Other			
Elevated Cholesterol				Sciatica				Car Accident			
Allergies				Fatigue				Insomia			
Respiratory/Lung				Numbness				Diabetes			
Varicose Veins				Blood Clots				Other			

Have you had any surgery in the past 5 years? (circle) Yes / No
If yes, please list:

Do you have a Pacemaker? (circle) Yes / No

Please circle if you have a family history of any of the following:
Heart Attack Elevated Cholesterol Heart Disease High Blood Pressure Stroke Diabetes

Do you smoke? (circle) Yes / No If yes, Packs per day?

Do you consume alcoholic beverages? (circle) Yes / No

Have you recently had any additional stress in your life? Yes / No If yes, please explain:

_____

Do you exercise regularly? (circle) Yes / No If yes, how often? _____ / week

List all medications you are currently taking:

_____
_____

FEMALES: Do you believe you may be pregnant? (circle) Yes / No
Are you currently taking hormones or hormonal contraceptives? (circle) Yes / No

What is your chief complaint/condition that made you seek out physical therapy services?

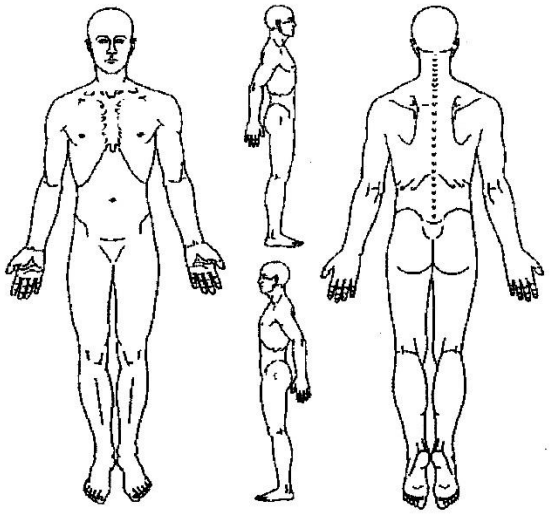
_____
_____

What is the date of onset of the problem/complaint? _____ / _____ / _____

Have you see a physician specifically for this problem/complaint? (circle) Yes / No
If yes, Whom?(full name please): _____
Also, if yes; when is your follow-up appointment with this physician? ____ / ____ / ____

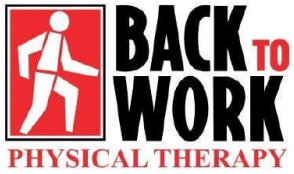
Have you ever been [or are currently being] treated for the same condition you are presently here for? (circle) Yes / No

Have you had surgery related to this problem/complaint? (circle) Yes / No If yes, When? ____ / ____ / ____
On the diagram below, please indicate with the letters below where you are experiencing any of the following: **A** = Aching **P** = Pins & Needles **B** = Burning **S** = Stabbing **N** = Numbness **T** =Tightness **O** = Other



Patient Name:

Please indicate the intensity of these symptoms at this time: (circle) Non-existent 0 1 2 3 4 5 6 7 8 9 10 Intolerable
What activities/treatments make your condition improve?
What activities/treatments make your condition worsen?
What are your expectations/goals for physical therapy treatment?
Please list any other pertinent information that may be useful to the Physical Therapist:



Medical Records Release

Patient's name _____

Date of Birth _____/_____/_____

Please release my medical records from
Back to Work Physical Therapy
PO Box 3147
Tampa, Fl 33601-3147
813-253-3092

To: _____

_____

_____

_____

Please release all records, including but not limited to, initial evaluation, progress notes, evaluative tests, and discharge summary.

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS PROVIDED ABOVE.

This authorization is valid from _____ to _____.

_____ Date _____
Patient's signature

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

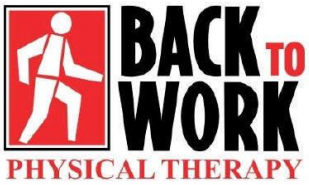
D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**):*

Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.



*****FOR AUTO INJURY PATIENTS ONLY****

DIRECT PAYMENT AUTHORIZATION WITH ASSIGNMENT Of BENEFITS

This agreement allows me, the named patient/insured to be treated by Back To Work Physical Therapy, without paying for my care and treatment in advance. The company above will be paid within 30 days of submission of claims for my care directly by my Personal Injury Protection carrier. This mutual consideration is considered good and sufficient by the parties. I hereby guarantee full payment to the above companies and agree that I will remain personally responsible for any unpaid charges. I also grant the above companies a lien against any recovery which I may have now or in the future against any tortfeasor or any responsible insurance carrier. I promise to sign a Letter of Protection in favor of the above companies and I hereby direct that any attorney representing me now or in the future execute a letter of protection in favor of the above companies. I hereby authorize and direct you, my personal injury protection insurance company or companies, to pay directly to the above companies, my personal injury benefits are for care and treatment rendered to me by the above companies. I am assigning my personal injury protection benefits rights including but not limited to the right to file legal suit to collect benefits under my personal injury protection policy. If any portion of this document is deemed to be inconsistent with an assignment of rights and benefits within the meaning of Florida Statutes 627.736, said portion shall be rewritten to conform with Florida law to give full effect to the intended purpose of this agreement, said intended purpose being to create an assignment of rights and benefits from the below named patient/insured to the above companies. I authorize and direct my present or future attorneys and my personal injury protection insurance companies to release medical and legal information to the named above companies.

_____

Patient Name (PRINT)

_____ _____

Signature of Patient or Legal Guardian Date