

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ SS #: _____ Gender: Male Female

Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

E-mail: _____ Marital Status: Single Married Widowed Divorced

Other Address: _____

City: _____ State: _____ Zip Code: _____

Is this condition the result of an accident? (auto, slip and fall, or work related) Yes No

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician: _____ Phone: (_____) _____ - _____

Referring Physician: _____ Phone: (_____) _____ - _____

How did you hear about us? Physician Friend Ad Lecture Health Fair Internet Other

EMERGENCY CONTACT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Phone: (_____) _____ - _____ Relationship to Patient: _____

As a courtesy all claims will be submitted to your primary and secondary insurance companies and all current guidelines will be followed. There is no absolute guarantee of payment in full by your insurance companies. You will be responsible for any deductibles not met, all co payments and amounts deemed patient responsibility by your insurance companies.

Patient Signature: _____ Date: _____

MEDICARE HOME HEALTH

Medicare will not cover Physical, Occupational or Speech Therapy services in our facility if you are having any type of Home Health Care provided by a Medicare Part A Certified Home Health Agency. Home Health Care includes Physical, Occupational and Speech Therapies, Wound Care, Nursing, Aides or Help with Medications. **If you have not been completely discharged by your Home Health Care Agency, you cannot have any Physical, Occupational or Speech Therapy services by Florida Movement Therapy Center – Gardens, LLC.**

Have you had any type of Home Care Therapy in the past 6 months? If yes, please provide the name

of the agency used. Yes No Name of Agency: _____

I, _____, understand that Medicare will deny payment for my Physical,
(Patient Name)
Occupational, or Speech Therapy treatments at this clinic if I am under the care of a Medicare Part A Home Health Agency.

Patient Signature: _____ Date: _____

MEDICARE DOLLAR CAP

Effective January 1, 2006 Medicare has placed a dollar amount cap on therapy services. Although there are exceptions to this cap amount, Medicare does track usage of all therapies each year. The Medicare Part B Cap is \$1980 per year for Physical and Speech Therapy combined and \$1980 for Occupational Therapy. Chiropractic and Home Therapy Services are not included in the Medicare Cap. **If you have received treatment in another facility and do not inform our office, it will complicate the billing process and possibly lead to a denial from Medicare.**

Have you had any therapy in any other facility since January 1, 2017?

Physical Therapy Yes No Discharge Date: _____

Speech Therapy Yes No Discharge Date: _____

Occupational Therapy Yes No Discharge Date: _____

Patient Name: _____ Date: _____

Patient Signature: _____

AUTHORIZATION AND RELEASE OF MEDICAL INFORMATION

I authorize **Florida Movement Therapy Center – Gardens, LLC** to provide therapy treatment by prescription/referral from the referring physician and as established on the plan of care created by the evaluating therapist. I authorize, as well, direct payment of medical bills to **Florida Movement Therapy Center – Gardens, LLC**.

I authorize **Florida Movement Therapy Center – Gardens, LLC** and its therapists to release to my referring physician, any guarantor, my employers, insurance company, or the Social Security Administration or its intermediaries, any information required to secure payment for charges incurred by me or on my behalf including diagnosis of my condition. I include in this information any information regarding HIV or AIDS status, substance abuse and psychiatric history.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

You are entitled to receive a copy of our *Notice of Privacy Practices*. You may ask for a copy of this notice at any time by contacting **Florida Movement Therapy Center – Gardens, LLC** at 561.619.9520.

If you believe your privacy rights have been violated, you may file a complaint with **Florida Movement Therapy Center – Gardens, LLC** or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, please contact us at **Florida Movement Therapy Center – Gardens, LLC**, 8645 North Military Trail, Suite 401, Palm Beach Gardens, FL 33410. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note that we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Florida Movement Therapy Center – Gardens, LLC**, 8645 North Military Trail, Suite 401, Palm Beach Gardens, FL 33410, 561.619.9520.

I have received the right to request a copy of **Florida Movement Therapy Center – Gardens, LLC** Notice of Privacy Practices.

The patient and all involved understand that this signature on file revokes all prior dated signature on file, and they are hereby declared null and void and are substituted by this signature on file.

Patient Name: _____ Date: _____

Patient Signature: _____

(Parent or Guardian if patient is a minor)

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

Height: _____ Weight: _____ Are you: Right Handed Left Handed
(Circle one)

What is the primary complaint you are receiving therapy for? _____

When did this problem begin? _____

Do you have a history of similar symptoms? _____

Have you had episodes of this same complaint treated in therapy? Yes No

Before this problem began, did you have any limitations in these areas:

- Self-Care Mobility Changing and/or maintaining body position
- Carrying, moving and handling objects I had no functional limitations before this problem

What are your current functional limitations? Mark any difficulties that apply due to this problem:

- | | | |
|--|--|---|
| <input type="checkbox"/> Climbing stairs | <input type="checkbox"/> Moving around obstacles/in crowds | <input type="checkbox"/> Reaching |
| <input type="checkbox"/> Driving community distances | <input type="checkbox"/> Moving from bed to chair | <input type="checkbox"/> Shopping |
| <input type="checkbox"/> Food prep/Meal cooking | <input type="checkbox"/> Moving in/out of car | <input type="checkbox"/> Sleep |
| <input type="checkbox"/> Housekeeping | <input type="checkbox"/> Prolonged sitting | <input type="checkbox"/> Squatting |
| <input type="checkbox"/> Kneeling | <input type="checkbox"/> Prolonged standing | <input type="checkbox"/> Walking between rooms |
| <input type="checkbox"/> Laundry | <input type="checkbox"/> Pulling objects | <input type="checkbox"/> Walking long distances |

Who do you live with? _____ Do you have stairs at home? Yes No

Have you fallen in the last year? Yes No If yes, how many times? _____

Please list:

Surgeries:	Allergies:	Medication:	Dosage:	Frequency:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please check YES or NO if you have had or are currently affected by any of the following:

Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement
<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Lupus
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy
<input type="checkbox"/>	<input type="checkbox"/>	Asthma or Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Fracture	<input type="checkbox"/>	<input type="checkbox"/>	Obesity
<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker
<input type="checkbox"/>	<input type="checkbox"/>	Bowel or Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's disease
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack or Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Problems with Speech
<input type="checkbox"/>	<input type="checkbox"/>	Cauda Equina Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	High/Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Current Infection	<input type="checkbox"/>	<input type="checkbox"/>	Huntington's Chorea	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco
<input type="checkbox"/>	<input type="checkbox"/>	Dementia	<input type="checkbox"/>	<input type="checkbox"/>	Immunosuppression	<input type="checkbox"/>	<input type="checkbox"/>	Traumatic Brain Injury
						<input type="checkbox"/>	<input type="checkbox"/>	Vision Difficulties
						<input type="checkbox"/>	<input type="checkbox"/>	Weight Gain/Loss

Please rate your pain due to this problem:

At Worst: 0 1 2 3 4 5 6 7 8 9 10

Currently: 0 1 2 3 4 5 6 7 8 9 10

At Best: 0 1 2 3 4 5 6 7 8 9 10

How do you describe this pain:

- Burning Constant Dull/Achy Intermittent Numbness/Tingling Sharp
 Shooting Throbbing Worse in AM Worse in PM Worse at Night

What makes this pain worse:

- Bending Coughing/Sneezing Lying Down Sitting Standing Stairs-Up
 Stairs-Down Sit to Stand Voiding Walking

Is there any other health information that we should know about? Yes No

If yes, please specify: _____

Patient Signature: _____ Date: _____

Reviewed by Therapist: _____ Date: _____