PATIENT DEMOGRAPHIC FORM

FLORIDA MOVEMENT THERAPY CENTERS™

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:** ________________________________

FLORIDA MOVEMENT THERAPY CENTERS™

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 – Boynton Beach, 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 $2010 per year for Physical and Speech Therapy combined and $2010 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, 2018?

Physical Therapy ☐ Yes ☐ No Discharge Date: ______________________________

Speech Therapy ☐ Yes ☐ No Discharge Date: ______________________________

Occupational Therapy ☐ Yes ☐ No Discharge Date: ______________________________

Patient Name: ______________________________ **Date:** ______________________________

Patient Signature: ____

FLORIDA MOVEMENT THERAPY CENTERS™

AUTHORIZATION AND RELEASE OF MEDICAL INFORMATION

I authorize **Florida Movement Therapy Center – Boca Raton, 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 – Boynton Beach, LLC**.

I authorize **Florida Movement Therapy Center – Boynton Beach, 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 – Boynton Beach, LLC** at 561.733.5083.

If you believe your privacy rights have been violated, you may file a complaint with F**lorida Movement Therapy Center – Boynton Beach, 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 – Boynton Beach, LLC**, 12040 South Jog Road, Suite 8, Boynton Beach, FL 33437. 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 IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI 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 – Boynton Beach, LLC**, 12040 South Jog Road, Suite 8, Boynton Beach, FL 33437, 561.733.5083.

I have received the right to request a copy of **Florida Movement Therapy Center – Boynton Beach, 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)

FLORIDA MOVEMENT THERAPY CENTERS™

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:

☐ Climbing stairs	☐ Moving around obstacles/in crowds	☐ Reaching
☐ Driving community distances	☐ Moving from bed to chair	☐ Shopping
☐ Food prep/Meal cooking	☐ Moving in/out of car	☐ Sleep
☐ Housekeeping	☐ Prolonged sitting	☐ Squatting
☐ Kneeling	☐ Prolonged standing	☐ Walking between rooms
☐ Laundry	☐ Pulling objects	☐ 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:**

PATIENT INTAKE FORM

FLORIDA MOVEMENT THERAPY CENTERS™

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

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