Physical Therapy Services
Medical History Form

Last Name _____ First Name _____ DOB _____ Age _____

Diagnosis: _____

Physician: _____

Check Yes or No. If yes, please explain in the space provided.		
☐ Yes	☐ No	Are you pregnant? _____
☐ Yes	☐ No	Currently being treated elsewhere for this or another injury?_____
☐ Yes	☐ No	History of high or low blood pressure? _____
☐ Yes	☐ No	History of heart disease? Heart attacks/M.I? _____
☐ Yes	☐ No	Presently have a pacemaker? _____
☐ Yes	☐ No	Previous strokes/CVA? _____
☐ Yes	☐ No	History of any illness (i.e., diabetes, asthma, seizures, etc.)?_____
☐ Yes	☐ No	Current/history of any skin diseases?_____
☐ Yes	☐ No	Any emotional/psychological disturbances? _____
☐ Yes	☐ No	Please list current medications. _____
☐ Yes	☐ No	Any allergies?_____
☐ Yes	☐ No	Respiratory difficulties? _____
☐ Yes	☐ No	Any bowel or bladder disturbances? _____
☐ Yes	☐ No	Any unusual bleeding?_____
☐ Yes	☐ No	Any unusual reactions to heat or cold?_____
☐ Yes	☐ No	Special diet restriction? _____
☐ Yes	☐ No	Any present visual problems? _____
☐ Yes	☐ No	Any present hearing problems (including hearing aids)?_____
☐ Yes	☐ No	Do you smoke? How many packs a day? _____
☐ Yes	☐ No	Is visit accident related? Work? Auto? Other?_____
☐ Yes	☐ No	History of fractures? Dislocations? _____
☐ Yes	☐ No	Arthritis or joint problems? _____
☐ Yes	☐ No	Sensory disturbances? _____
☐ Yes	☐ No	Any current movement/tasks unable to perform?_____
☐ Yes	☐ No	Do you require any special help at home? _____
☐ Yes	☐ No	Previous hospitalizations/surgeries/cancer? _____
☐ Yes	☐ No	Please list recreational activities (including prior to visit). _____
☐ Yes	☐ No	Do you have any other form of health insurance coverage? If yes, please print the name of the insurance policy:_____

I, the undersigned, do hereby authorize the release of any information, including reports of diagnosis, treatment prognosis, recommendation, benefits payable, as well as other data pertinent to my treatment to the physician who referred me for therapy, and/or to any organization or person responsible for the payment of my account. A copy of this can be considered as an original for insurance purposes and valid as an original.

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give consent for Physical Therapy Services to furnish medical care and treatment considered necessary and proper in evaluating and treating my physical condition. I, the undersigned, will allow Physical Therapy Services to receive/send medical records pertaining to my condition via fax machine and/or mail. **I HAVE READ AND UNDERSTAND THE ABOVE POLICIES**.

X_____ X _____

Patient or Guardian's Signature Date Therapist's Signature Date

UPDATED 02/24/2015

physical therapy services

"Relief Lies Within"

PATIENT INFORMATION	LAST NAME FIRST M.I.	PHONE NO.	CELL PHONE NO.	E-mail	
	STREET ADDRESS	CITY STATE ZIP			
	SOCIAL SECURITY NO.	BIRTHDATE AGE	OCCUPATION	EMPLOYER'S NAME PHONE NO.	
	EMPLOYER'S STREET ADDRESS	CITY STATE ZIP			
	REFERRING PHYSICIAN	PRIMARY PHYSICIAN	HEIGHT	WEIGHT	
EMERGENCY CONTACT	NAME OF PERSON TO NOTIFY	RELATIONSHIP TO PATIENT	HOME PHONE	WORK PHONE	
	STREET ADDRESS	CITY STATE ZIP			

"I understand in the event I default on my balance, my account will be charged for all and any collection fees, attorney fees and court costs. I understand these fees will be my responsibility."

$30.00 cancellation fee will be assessed for appointments canceled without 24 hour notice.
$50.00 cancellation fee will be assessed for 5pm and 6pm appointments canceled without 24 hour notice.

ESTIMATE

	Calendar Year Deductible for Primary	**Met**
	% Co-insurance	
	Co-payment for Visit	

Please note: *Estimate amounts may change as the therapist updates your rehabilitation program.*
I choose to have my insurance company assign benefits to your office. I understand that any portion of the estimate amount not paid by my insurance company and claims not paid within 60 days will be my responsibility and I will pay the balance. I hereby assign benefits to your physical therapy office.

_____ _____

Patient Signature Date

Thank you for choosing Physical Therapy Services.

UPDATE 03/26/2015

Penemarie K. Murphy, Inc dba Physical Therapy Services

Relief Lies Within

ASSIGNMENT OF BENEFITS

I, _____, authorize _____
(Patient's Name Printed) (Insurance Company)
to make medical benefits payments otherwise payable to me for services rendered by Physical Therapy Services, but not to exceed the charges of those services, payable to and mailed directly to

Physical Therapy Services
P.O. Box 11677
Jacksonville, FL 32239

I hereby instruct the insurance carrier that in the event that the subject medical benefits are disputed for any reason, including medical reasonableness and/or necessity, that the amount of the unpaid benefits claimed by **Physical Therapy Services** is to be set aside and not disbursed until the dispute is resolved.

Furthermore, I hereby IRREVOCABLY ASSIGN to **Physical Therapy Services** the rights and benefits and any and all causes of action resulting from nonpayment under any policy of insurance, indemnity agreement or any other collateral source as defined by Florida Statutes for any service and/or charges provided by **Physical Therapy Services.**

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this _____day of _____, 20_____.

_____ _____
(Patient's Name – Printed) (Patient's Signature)

_____
(Provider Signature)

☐ 7001 Merrill Rd • 32277 • (904) 744-0277
☐ 12740-2 Atlantic Blvd • 32225 • (904) 220-8311

UPDATED 01/29/2015

Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of Your Protected Health Information
Your protected health information will be used by Physical Therapy Services or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-today health care operations of the practice.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your protected information may be used or disclosed. You may review the prior notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information
You may request a restriction on the use or disclosure of your protected health information.

Physical Therapy Services may or may not agree to restrict the use or disclosure of your protected health information.

If Physical Therapy Services agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices
Physical Therapy Services reserves the right to modify the private practices outlined in the notice.

Acknowledgment and Signature
I hereby acknowledge I have received and had and opportunity to ask question concerning the above named practice's Notice of Privacy Practices.

_____
Signature Date

Signature
I have reviewed this consent form and give my permission to Physical Therapy Services to use and disclose my health information in accordance with it.

_____
Name of Patient (Print or Type)

_____
Signature of Patient Date

_____
Signature of Patient Representative Relationship to Patient

☐ 7001 Merrill Rd • 32277 • (904) 744-0277

☐ 12740-2 Atlantic Blvd • 32225 • (904) 220-8311

UPDATED 01/29/2015

Notification of Auto Insurance Patient Initiation of Treatment

Date _____ Date of Initiation of Treatment _____

Patient Name _____

Social Security # _____ Claim # _____

Date of Birth _____ Date of Accident _____

Address _____

City _____ State/Zip _____

Phone # _____ Work # _____

Doctor _____ Date of Last Doctor Visit _____

Office # _____ Fax # _____

Diagnosis/Area _____

Frequency of treatment _____ X per week for _____ weeks

Copy of Physical Therapy Initial Evaluation enclosed? : ☐ Yes ☐ No

Form OIR-B1-1571 enclosed (original in today's mail) ☐ Yes

☐ 12740-2 Atlantic Blvd • Jacksonville • 32225 (904) 220-8311 • 220-8313(fax)
☐ 7001 Merrill Rd. • Jacksonville • 32277 (904) 744-0277 • 744-0263(fax)

Mail all Correspondence to our billing office: PO Box 11677 • Jacksonville, FL 32239 (904) 745-0302

Instructions to authorized receiver:
Please complete this statement of receipt and return to sender via the above fax number.

I_____ verify I have received _____
(number of pages_____ including the cover sheet)

From: _____ Date: _____
(sending facility name)