Physioactive
Physical Therapy & Wellness Center

NEW PATIENT INFORMATION

Kindly complete this form

NAME: _____ DATE OF BIRTH: _____

AGE: _____ SS#: _____ EMAIL: _____ SEX: F M

MARITAL STATUS: __ SINGLE __ MARRIED __ DIVORCED __ WIDOWED __OTHER

LOCAL ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ HOME PH: _____ CELL: _____

PERMANENT ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ HOME PH: _____

OCCUPATION: _____ EMPLOYER/SCHOOL: _____ RETIRED ___

SPOUSE/EMERGENCY CONTACT: _____ PHONE: _____

REFERRED BY: _____PRIMARY CARE PHYSICIAN: _____

PRIMARY INSURANCE: _____ INSURED'S NAME: _____

I, _____, authorize the release of any medical information necessary to process my insurance. I authorize the payment of medical benefits to Physioactive LLC for any services furnished to me by this physician when insurance is applicable. I understand that I am financially responsible for all charges for all services rendered.

Patient's signature: _____ Date: _____

7700 Congress Ave, Suite # 2102, Boca Raton, Florida 33487 Ph: (561)241.5499 Fax (561)228.5957

Financial Responsibility and Insurance Authorization
Consent for Treatment

As a courtesy to you, our Admissions Department verifies your current insurance coverages and deductible before treatment begins. Outpatients therapy services are billed under the Medicare Part B Fee Schedule. If you are covered under Medicare, Medicare will pay for reimbursable charges of our services at 80% of the covered amount. We will bill your co-insurance, or we will bill, for the remaining allowable 20%. If you are covered under a different insurance policy, a copy of our Insurance Verification will be provided to you so that you are aware of the projected out of pocket expense. However, please know that verification of coverage is not an authorization for payment. We will be happy to bill your insurance company on your behalf, however, if for any reason your insurance company does not pay, the charges are your responsibility.

Insurance Benefits

I certify that my primary insurance is _____

I certify that my secondary insurance is _____

Financial Acknowledgment:

- I acknowledge that any change to my primary or secondary insurance could affected my financial responsibility and that I will notify Physioactive, LLC is I change my primary or secondary insurance
- I understand and acknowledge my financial responsibility for any co-payment, deductible, out of pocket or co-insurance outstanding not covered by my insurance policy, it will be paid prior to the services provided and any outstanding balance will be charged to my credit card on record.
- I authorize payment directly to Physioactive, LLC due to me in my pending claim and/or major medical benefits otherwise payable to me, not to exceed the charges for this period treatment.
- I understand that if payment is issued directly to me, it is my responsibility to forward this payment to Physioactive, LLC.
- I authorize my evaluation to be performed by a licensed physical therapy and treatment will delivered as necessary for my recovery and I will be compliant with my appointment and plan for care.
- I certify that I am not currently receiving any services from a home health agency or outpatient rehabilitation facility. If I purpose deceive Physioactive, LLC of this, then I may be held responsible of payment for services. I confirm that prior to starting any home health services, I will notify Physioactive, LLC.
- Should this account go delinquent, I agree to pay all costs of collection agency fees, court costs and attorney fees.

_____ _____

Patient name (print and sign) Date

Physioactive
Physical Therapy & Wellness Center

This Consent Form has been developed in response to regulations set forth under HIPAA (Health Insurance Portability and Accountability Act). This regulation includes Privacy Standards intended to protect your health information from being distributed without your consent. "Protected Health Information" means health information, including demographic information and medical information related to your past, present or future physical or mental health condition. This information includes information that is collected from you, created or received by a physician or another health care provider and information received from a health plan, an employer or a health care clearinghouse.

Under these regulations, which took effect on April 14, 2003, we are asking for your consent to release information for purposes of treatment, payment and our healthcare operations. Please read the following and feel free to ask any questions that you may have.

Consent for Purposes of Treatment, Payment and Healthcare Operations:

I consent to the use or disclosure of my protected health information by Physioactive, LLC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of this facility. I understand that treatment of me by the Program Therapists may be conditioned upon my consent as evidence by my signature on this document.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physioactive, LLC has taken action in reliance on this consent.

My signature below indicates that a copy of Physioactive "Notice of Health Information Practices" is available to me upon request and was available to me today.
The document describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bill or in the performance of health care operations of the Center and my rights and Center's duties with respect to my protected health information.

_____ _____

Patient Name (Sign and Print Name) Date

Physioactive
Physical Therapy & Wellness Center

NAME: _____ DATE:_____

Medications: _____

_____

Drug allergies and reactions: _____

Social History

Do you smoke cigarettes? □Yes □No Number of cigarettes day_____?

Did you ever smoke? □Yes □No Do you drink alcohol? □Yes □No Number of drinks per day?_____

Do you have a history of alcohol abuse? □Yes □No Or drug abuse? □Yes □No

Do you have steps at home? □Yes: how many?_____ □No. With whom do you live?_____

Family history *including illnesses, and if applicable, cause of death.*

Mother:_____ Father:_____

Surgeries:_____

_____

REVIEW OF SYSTEMS — *CHECK ANY POSITIVE FINDINGS* □ CHECK HERE IF NONE APPLY

GENERAL
- □ Weight changes
- □ Weakness
- □ Fatigue
- □ Fever
- □ Difficulty sleeping
- □ Sore throat
- □ Night Sweats
- □ Chills

HEAD
- □ Headache
- □ Vision problems
- □ Glaucoma
- □ Cataracts

HEARING
- □ Ear ache
- □ Dizziness
- □ Nasal problems

RESPIRATORY
- □ Cough/Phlegm
- □ Pneumonia
- □ Short of breath
- □ Tuberculosis

CARDIAC
- □ Chest pain
- □ Palpitations
- □ Murmur
- □ Pacemaker

GASTRO
- □ Nausea/vomiting
- □ Indigestion
- □ Pain
- □ Diarrhea
- □ Bleeding
- □ Constipation

GU
- □ Urinary pain
- □ Urinary tract infection
- □ Menstrual problem
- □ Menopausal symptoms
- □ Impotence

SKELETAL
- □ Stiffness
- □ Swelling
- □ Cramps
- □ Varicose veins

NEURO
- □ Fainting
- □ Paralysis
- □ Weakness
- □ Tremor
- □ Tingling
- □ Seizures
- □ Memory problems
- □ Numbness

ENDOCRINE
- □ Temp. Intolerance
- □ Frequent urination
- □ Hunger
- □ Thirst

HEMATOLOGIC
- □ Anemia
- □ Bruising
- □ Transfusions
- □ Allergies
- □ Bleeding

PSYCH
- □ Anxiety
- □ Nervousness
- □ Tension
- □ Depression
- □ Mood swings

SKIN
- □ Rashes
- □ Lumps, breast or other
- □ Itching
- □ Hair changes
- □ Nail changes

OTHER
- □_____
- □_____
- □_____
- □_____

Physioactive
Physical Therapy & Wellness Center

Name: _____ Date: _____

Age: _____

Please answer all applicable questions that most describe your condition.

What is your most significant problem?_____

When did it begin? ___/___/___ Is it constant? _____ or Intermittent? _____

To what do you attribute your pain or condition? _____

How do you rate your pain? (0= absence of pain, 10= worst pain imaginable)_____

Did it occur spontaneously? _____ YES _____NO Did occur due to an accident? _____ YES _____ NO

Does your pain radiate or shoot? _____ If so, to where? _____

Does any of the below actions worsen you pain?
□ walking □ standing □ laying □ changing position □ coughing □ laughing

What makes your pain or condition worse? _____

What makes your pain or condition better? _____

For your condition, have you seen a Physician? Y or N Chiropractor? Y or N Therapist? Y or N

What have they told you? _____ What have they done?_____

Names (s) of those seen: _____

Have you had any recent bladder or bowel changes? □ YES □ NO

Have you had any weakness of the arms or legs? □ YES □ NO

Please note the diagnostic test(s) you have had specific to your condition and write the results if you know them:

Nerve Conduction Study (NCS)/ Electromyogram (EMG) results: _____

MRI/ CT Scan results: _____

X-Ray results: _____