ReQuest
PHYSICAL THERAPY
Comprehensive care with a personal touch

PATIENT SUMMARY

To better serve you, it is important that you complete this medical history as completely and as accurately as possible

PART IA PERSONAL INFORMATION

Name (as you like to be addressed) _____

Mailing Address _____

_____

_____

Age ____ Date of Birth _____ Home Phone Number (____)_____ Email_____

Date of Initial Injury _____ Referring Physician _____

Date of Most Recent Increase of Symptoms _____ Primary Care Physician _____

Please check the appropriate response

	YES	NO
Do you smoke?		
Do you exercise regularly?		
Is your current condition work accident related?		
Is your current condition auto accident related?		
Have you had physical, occupational, speech, massage or chiropractic care for any reason this year?		

PART I PAST MEDICAL HISTORY

Please check YES if you have ever (in your life) had, or do you presently have any of the following

		YES
1	Anemia / Blood Disease	
2	Bone / Joint Problem	
3	Arthritis / Rheumatism	
4	Allergies	
5	Back Trouble	
6	Breathing Problems (any kind)	
7	Broken Bones / Dislocation / Sprains	
8	Cancer or Tumor	

		YES
9	Diabetes	
10	Dizziness / Fainting	
11	Epilepsy / Seizure Disorder	
12	Fibromyalgia Syndrome	
13	Headaches	
14	Head / Spinal Injury	
15	Heart Disease / Chest Pain	
16	Hernia / Rupture	

		YES
17	High Blood Pressure or High Cholesterol	
18	Lung Disease	
19	Paralysis	
20	Pregnancy (Current)	
21	Skin Disease or Sores That Won't Heal	
22	Stroke	
23	Swelling of Feet or Joints	
24	Other	

Please give details of all above YES answers below (listing the corresponding number)

Number	Illness Details

Please continue on Back

PART II PAST SURGERIES

If you have had any prior surgeries please give details below

Surgery / Procedure	Date

PART III MEDICATIONS

Are you allergic to any medications? YES / NO If YES, what? _____

If you are currently taking any medications please list below

Medication	
1	
2	
3	
4	

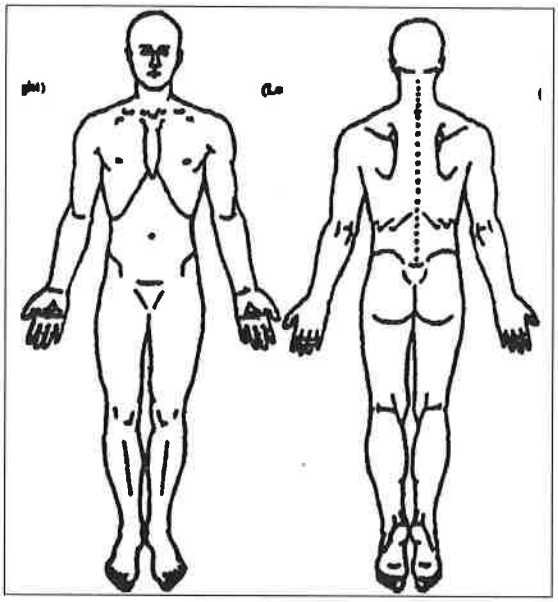
Medication	
5	
6	
7	
8	

PART IV PAIN LEVEL EVALUATION

Using the 0 to 10 scale below, please circle your pain level during the last week

Using the chart below and to the right, please indicate with an "X" the location of any pain, numbness or tingling you have experienced during the last week

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Severe Pain**



"I certify that I have reviewed and understand the above information supplied by me, and that it is true and correct to the best of my knowledge"

_____ _____

Patient Signature **Date**

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INSURANCE ASSIGNMENT AGREEMENT AND AUTHORIZATION TO RELEASE INFORMATION

RELEASE OF INFORMATION I, the below named patient, hereby authorize Request Physical Therapy to release to any third party payer (such as an insurance company or governmental agency, example: Blue Cross of Florida or Medicare) any medical condition and records concerning diagnosis and treatment when request by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

THERAPIST/CENTER INSURANCE ASSIGNMENT I, the below named patient, hereby authorize payment directly to Request Physical Therapy and/or any therapist examining or treating me for any group and/or individual medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services. I understand and agree that the center providing services is based on a treatment team approach to care. The treatment team consists of physical therapists, physical therapist assistants, licensed massage therapists, exercise specialists, athletic trainers and interns in training working under the direction and supervision of the treating physical therapist.

MEDICARE PATIENT'S CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST I, the below named patient, certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carriers, any information needed for this or a related Medicare claim. I hereby certify all insurance pertaining to treatment shall be assigned to the center/therapist treating me.

MY RESPONSIBILITY I, the below named patient, understand it is my responsibility to pay at time of service any deductible amount, co-payment, co-insurance or any other balance not paid for by my insurance. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL, WHICH IS ON FILE AT REQUEST PHYSICAL THERAPY. This assignment will remain in effect until revoked by me in writing.

INSURANCE DISCLAIMER

PLEASE CONTACT YOUR INSURANCE COMPANY TO VERIFY YOUR OUTPATIENT PHYSICAL THERAPY BENEFITS by contacting the customer service number located on the back of your insurance card(s). We will also verify these benefits as a courtesy to you. Information received from your insurance company is a quotation of benefits and is not a guarantee of coverage or payment. It is your responsibility to understand your contract with your insurance company. We will collect from you based on the information provided to us. If the info is inaccurate, you exhaust your benefit limit, or your insurance changes during treatment, you are responsible for the full payment on all services that are denied or not covered by your insurance. Please be advised that your deductible and out of pocket maximums will only reflect claims that have been processed by your insurance company. This may be different from what you feel you have paid as some facilities bill less frequently and we submit claims on a daily basis.

If you do not have insurance coverage or if you have exhausted your benefit limit, we offer a self-pay option. We will not submit any self- services to your insurance.

If you are receiving services through another provider (ex: chiropractic/speech pathology/massage therapy/acupuncture), please know those visits are being counted toward your yearly benefit limitations. It is your responsibility to keep track of all of your visits as well as your visit limitations. Do not schedule appointments with any of the above examples on the same day you have scheduled with our office or your insurance will deny for Benefit Maximum.

I have read all of the above information and understand that I am financially responsible for all service rendered by Request Physical Therapy.

Patient/Guardian Signature: _____ Date: _____

PCC Signature: _____ Date: _____

Appointment Reminder & Email Consent

Complete this form and sign below to give your permission for ReQuest Physical Therapy to provide automatic appointment reminder service by email or by cell phone text message.

Step One: Select One Option Below

- ☐ ReQuest Physical Therapy may send email messages to confirm my upcoming appointments to: _____.
- ☐ ReQuest Physical Therapy may send cell phone text messages to confirm my upcoming appointments to: _____.

Step Two: If you would like text message instead of email reminders, please indicate your cell phone carrier. We cannot set your account up to send text message reminders without knowing your cell phone carrier. Please indicate your carrier below, if you would like text message reminders:

- ☐ ALLTel
- ☐ AT&T
- ☐ Bluegrass Cell
- ☐ Boost Mobile
- ☐ C Spire
- ☐ C Spire Wireless
- ☐ Cellcom
- ☐ Cingular
- ☐ Cricket Wireless
- ☐ GCI
- ☐ Illinois Cellular
- ☐ Metrocall
- ☐ MetroPCS
- ☐ Nextel
- ☐ Pioneer Cellular
- ☐ Qwest
- ☐ Sprint PCS
- ☐ T Mobile
- ☐ US Cellular
- ☐ Verizon
- ☐ Virgin Mobile

Step Three: Please write your email address on the line if you would like to receive education emails from ReQuest Physical Therapy _____

Step Four: How did you hear about us? _____

Step Five: Are you a member of Gainesville Health & Fitness Center? Yes/No (please circle one)

_____
Signature of Patient or Guardian

_____
Date

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Policies and Procedures

As a patient, you have a choice in the care you receive and we are happy you have chosen us! You are more than a patient to us – you are part of the ReQuest Family. Our primary goal is to provide exceptional care while maintaining an excellent relationship with you and your physician. We work hard to ensure a respectful working environment for patients and staff alike.

Treatment Expectations

Your treatment will be a collaborative effort. We utilize a team-based approach, which includes a primary therapist as well as licensed physical therapist assistants, licensed massage therapists, exercise specialists, and student interns. Your primary therapist will oversee your treatment and will work with you and your physician to determine your plan of care.

We cannot schedule appointments past the plan of care certified by your physician. If we are unable to obtain the documentation necessary to continue your treatment, you may need to return to your physician.

Minors are not allowed in the clinic space unless they are a patient.

Privacy Policy

Our clinic is an open gym-type setting which means your treatment may take place in an open environment. We strive to respect your privacy rights and expect you to be respectful of other patients and staff. Your therapy can be terminated due to non-compliance or neglect of these policies. If at any point you feel uncomfortable during your treatment, please notify our staff immediately.

There is a Notice of Privacy Practices flier available at the front desk.

If you provide an email to us, we may use it for internal marketing. You can opt out of these emails at any time.

I acknowledge the above policies and procedures. **I have received a copy of the Patient Bill of Rights as outlined on the back of this form.**

Patient Attendance Policy

In order to assure all patients receive the time and attention they deserve, the following guidelines have been established:

1. If you are 15 minutes late for a scheduled appointment without notification, you may not be able to be seen that same day.
2. If you need to cancel an appointment, please notify us 48 hours in advance. If your call is not during our normal business hours, please leave a message on our voicemail.
3. **If you cancel in less than 24 hours for any reason, other than illness, for 2 scheduled appointments or no show for 1 scheduled appointment, you will be charged a $25 fee and can be discharged for noncompliance per your therapist's discretion.**

"I have read and understand this policy."

Patient / Guardian Signature _____ **Date:** _____

Consent to Disclose Patient Information / HIPAA

"I understand this center's Notice of Privacy Practices and give permission for my protected health information to be disclosed for purposes of communicating results, findings, care decisions and appointments to the family members or friends listed below:"

Name: _____

Name: _____

Name: _____

Patient Name (please print)_____

Patient / Guardian Signature _____ Date: _____

Reference Sheet

Provider Network: Insurance companies have a network of providers that they contract with. Benefits may vary based on the provider you choose. You can contact your insurance at any time to determine whether a provider is in or out of network for your policy and what your benefits are for that particular provider.

Deductible: Your treatment may be subject to your major medical deductibles, which is determined by your individual contract with your insurance provider. If your benefits are subject to a deductible, you will be responsible for the full allowable cost until the deductible is satisfied. Once the deductible is satisfied, you may still be responsible for a co-insurance. The amount you pay may vary at each visit based upon duration and/or type of treatment performed. Please be advised that your deductible will only reflect claims that have been processed by your insurance company.

Co-insurance: Your treatment may be subject to a co-insurance, which is a percentage that is determined by your individual contract with your insurance provider. The amount you pay may vary at each visit based upon duration and/or type of treatment performed.

Co-pay: Your treatment may be subject to a co-pay, which is a flat fee that is determined by your individual contract with your insurance provider. The co-pay is a flat fee that is not subject to duration and/or type of treatment performed.

Out of Pocket Maximum: Your out of pocket maximum is determined by your individual contract with you insurance provider. It is the maximum amount of money that you will be required to pay out of pocket. Once your out of pocket maximum has been satisfied, services will be covered at 100%.

Benefit Limitations: Your treatment will be subject to the benefit limitations set by your individual contract with your insurance provider. There may also be limitations based on the professional licensure of our clinicians. This can range from medical necessity to a visit limit or a monetary amount.

Authorization: Your treatment may be subject to authorization, which is determined by your individual contract with your insurance company or your individual claims with a worker's compensation or automotive insurance company. We will not schedule visits unless we have the authorization needed to properly submit your claims.

Self-pay: If you do not have insurance coverage or if you have exhausted your benefit limit, we are happy to offer a self-pay option. We will not submit any self-pay services to your insurance and payment will be due at the time of service. Once you elect to be a self-pay patient, we cannot bill any of those claims to an insurance provider.

Referral: A referral is the initial instructions provided to us by your physician. Your physician determines what body area (diagnosis) is being treated as well as the initial frequency and duration of your treatment. A referral shows proof of medical necessity and may be required by your insurance policy to initiate treatment.

Plan of Care: A plan of care will be created by your treating therapist at your initial evaluation. This plan of care will be sent your referring physician for a review and certification. This certification is necessary to continue treatment.

Direct Access: Some insurance companies will allow direct access to physical and massage therapy services. Under Direct Access laws, we can see you for a 30 consecutive day window without a referral. If your physician signs and returns your plan of care during this 30 days, a referral may not be required.

Patient Bill of Rights

A patient has the right to every consideration of their privacy concerning their own medical care program. Case discussion, consultation, examination, and treatment are considered confidential and should be conducted discreetly.

A patient has the right to expect that all communication and records pertaining to his medical care should be treated as confidential except as otherwise provided by law.

The patient has the right to expect emergency procedures to be implemented without unnecessary delay as well as good quality care and high professional standards that are continually maintained and reviewed.

The patient has the right to full information in layman's terms concerning diagnosis, treatment and prognosis that includes information about alternative treatments and possible complication. When it is not medically advisable to give such information to the patient, the information shall be given on his behalf to the patient's next of kin or to another appropriate person.

A patient has the right to physical therapy services without discrimination based upon race, religion, or sexual preference. Patients who do not speak English are permitted to bring an interpreter to his/her therapy sessions.

The patient has the right to good quality care and high professional standards that are continually maintained and reviewed.

The patient has the right to expect good management techniques be implemented within the facility out of consideration for the use of the patient's time and to avoid the personal discomfort of the patient.

The facility shall provide the patient, upon written request, access to all information contained in his or her medical records.

The patient has the right to examine and receive detailed explanation of his or her bill.