ON-SITE
Physical Therapy

Pre Evaluation Checklist

The following items need to be completed and returned to Onsite Physical Therapy prior to scheduling your Initial Evaluation. You can come by the fitness center anytime during normal business hours to fill these out and get your insurance cards copied.

___ Physical Therapy Prescription (**dated no longer than 30 days prior to Initial Evaluation with the therapist**)

___ Insurance Cards & Photo ID copied(including front and back of Secondary insurance card) We will make copies for you

___ Patient Registration form filled out & signed

___ Health History form filled out COMPLETELY
(**If you have had Home Health within the past 3 months bring your Home Health Discharge papers in**)

___Medications and dosage

___ HIPAA rights form Signed

___ Cancellation Policy Signed

___ Patient Responsibility

___ Covid Waiver

ON-SITE
Physical Therapy

PATIENT REGISTRATION INFORMATION

NAME (Last, First):_____

LOCAL (FLORIDA) STREET ADDRESS:_____

CITY, STATE, ZIP CODE:_____

OTHER RESIDENTIAL ADDRESS:_____

CITY, STATE, ZIP CODE:_____

DATE OF BIRTH:_____/_____/_____ **SS#** _____/_____/_____ **SEX: M / F**

TELEPHONES: HOME:_____ **CELL:**_____

Circle preferred Primary Phone Contact above

EMAIL ADDRESS:_____

Would You like to Receive your Statement via Email: Yes_____ No_____

EMERGENCY CONTACT:_____

TELEPHONES: HOME:_____ **CELL:**_____

REASON FOR VISIT TO ON-SITE PT?:_____

ONSET DATE OF ILLNESS:_____

REFERRING PHYSICIAN:_____ **PHONE:**_____

PRIMARY CARE PHYSICIAN:_____ **PHONE:**_____

QUESTION: HAVE YOU HAD ANY THERAPY SERVICES THIS YEAR? YES / NO

IF YES, WHERE AND WHEN?_____

ARE YOU RECEIVING ANY MEDICAL CARE AT HOME?: YES / NO (Incl. Blood Work)

Have you been involved in an accident? Yes / No
Car Ins: _____ Claim Number _____

I HERBY SWEAR ABOVE IFORMATION IS TRUE AND CORRECT:

AUTHORIZED SIGNATURE:_____ **DATE:**_____

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HEALTH HISTORY

Name: _____ Date: _____
Height/weight: _____
Please Check/Circle ALL THAT APPLY:

	Alzheimer's		Osteoarthritis
	Past/Current Cardiac Problems		Metal Implants (i.e. pins, plates)
	Pacemaker / Defibrillator		Seizures Disorder/ Epilepsy
	Cerebral Vascular Accident /TIA / Stroke		Anxiety or Panic Disorder
	Diabetes: Type I or II		Depression
	Fibromyalgia		Rheumatoid / Psoriatic Arthritis
	Fracture or Suspected Fracture		Prosthesis
	High Blood Pressure		Sleep Dysfunction
	Frequent Falls		Active Cancer/History of Cancer
	Osteoporosis/ Osteopenia		Hepatitis/ AIDS
	Angina/Chest Pain		High Cholesterol
	COPD/Emphysema/Asthma		Blood Clot/Thrombosis/Embolism/DVT
	Headaches/Migraines		Immunosuppressed
	Neurologic Disorders (MS/Parkinson's)		Past Joint Replacement
	Hearing impairments/HOH/Hearing Aides		Current Wounds / Infection
	Peripheral Vascular Disease (or claudication)		Joint Surgery Past/ Recent
	History of: Visual Impairment (cataracts, glaucoma, macular degeneration)		History of: Back Pain (neck pain, low back pain, degenerative disc disease, spinal stenosis)
	Gastrointestinal disease, Ulcer, Hernia, Reflux, bowel, liver, gall bladder		Kidney, Bladder, Prostate, Incontinence or Urination problems

REASON FOR VISIT TO ON-SITE PT?:_____

ONSET DATE OF ILLNESS:_____

Allergies:_____

Prior Surgeries:_____

_____

Other Important Conditions/Disorders: Please List:_____

_____

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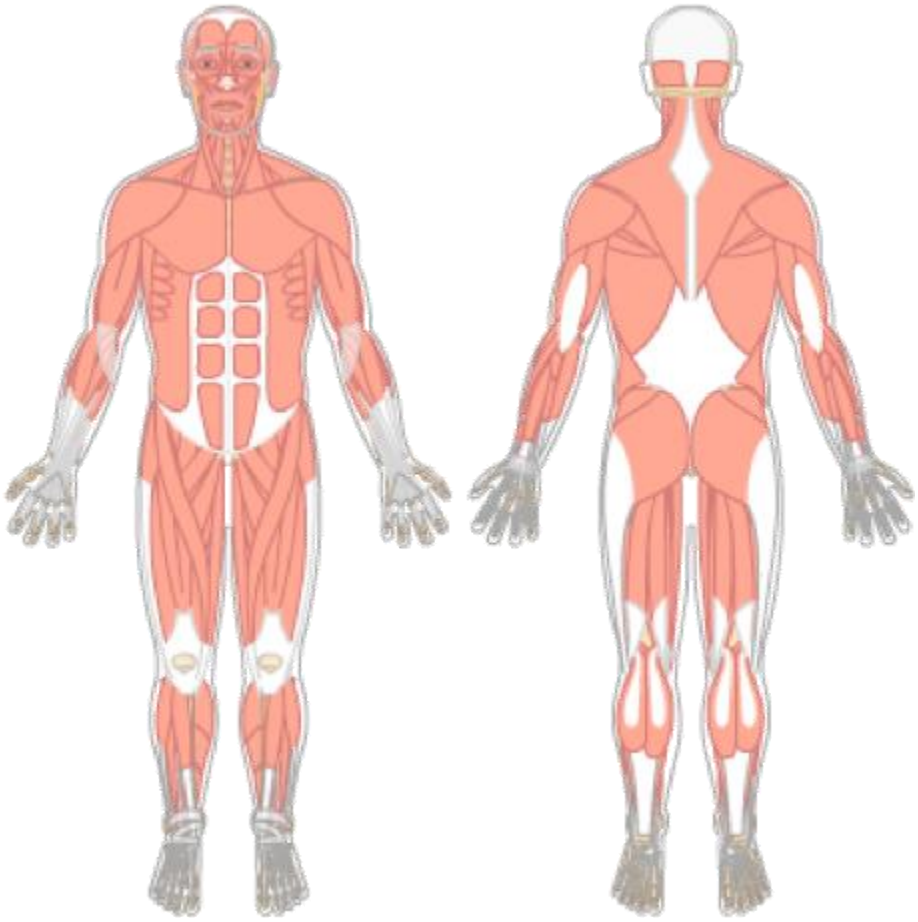
Name:_____ **Date:_____/_____/_____**

Use the Diagram below: Place "X" in All Locations where pain presents.



When I **DO NOT** take pain medication my pain level is:

No Pain **Worse Pain**

1 2 3 4 5 6 7 8 9 10 (Circle One)

ON-SITE
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PATIENT MEDICATIONS

MEDICATION	DOSAGE	MEDICAL ISSUE

This is only a summary of our Notice of Privacy Practices. The complete notice is attached for you, so you may learn how we use and disclose medical information about you, and your rights concerning these uses and disclosures. **Please Review it carefully**.

YOUR RIGHTS:

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those whom we have shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated
    - **See page 2 for more information on these rights and how to exercise them**

YOUR CHOICE:

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds
    - **See page 3 for more information on these choices and how to exercise them**

OUR USES AND DISCLOSURES:

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions
    - **See page 3 and 4 for more information on these uses and disclosures**

By signing below, I acknowledge I have received the summary of On-Site Physical Therapy LLC'S Notice of Privacy Practices, was offered the full notice, and understand my rights.

Patient Name: _____

Signature_____ **Date:**_____

-On-Site Physical Therapy, LLC

No-Show / Cancellation Policy *Please Read Carefully*

We realize that emergencies and other scheduling conflicts arise and are sometimes unavoidable, however, advance notification allows us to fulfill other patient's scheduling needs and keeps the clinic operating at its most efficient level. Due to our one-on-one 60-minute treatments, missed appointments are a significant inconvenience to your physical therapy, the clinic and other patients.

In addition, Medicare requires that you have at least **2 visits per week**. Unless otherwise stated by your therapist, you must make every effort to make and keep your scheduled appointment due to the possibility of Medicare not reimbursing Onsite PT for your care and you being charged.

1. Please provide our office with 24-hour notice to change or cancel an appointment. Patients who do not attend a scheduled appointment or do not provide **24-hour notice** to change a scheduled appointment may be responsible for a **$75.00** office visit charge, check or cash payable to On-site Physical Therapy LLC. This charge cannot be billed to insurance and **must be paid on or before the next scheduled appointment**. Cancellations due to sickness or family emergencies will be omitted.

2. Please **DO NOT CANCEL** if you are feeling worse and believe the treatment is not working. Keep your appointment and discuss any changes with your therapist. Please understand that your pain will probably fluctuate as your course of treatment progresses.

3. Please **DO NOT CANCEL** if you are feeling better. Keep your appointment in order to progress your plan and prepare for discharge.

Thank you for providing our office and our patients with this courtesy. Signing below indicates you understand and agree to the terms of this policy.

_____ _____

Signature of Patient Date

_____ _____

Signature of Responsible Party *(if applicable)* Date

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Patient Responsibility

I understand and agree that I am financially responsible for all charges for any and all services rendered. This includes any medical service or visit, routine examination.

I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

I understand and agree that it is my responsibility to know if my insurance has any deductible, copayment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full.

I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

If I am a Medicare patient, I understand that I need to provide the office both my Medicare ID card and my secondary ID card. If the office does not have the proper information for a secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement.

By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations, and/or as required by law. I have the right to revoke this Consent, in writing, signed by me.

_____

Printed Patient Name (and Guardian Name if applicable)

_____ _____

Patient Signature **Date**

PATIENT WAIVER OF LIABILITY RE: COVID-19
On-Site Physical Therapy, LLC

We are a COVID-19 sensitive facility and are committed to the safety, health, and well-being of our staff and patients. We have taken every precaution recommended by the Department of Health to ensure our environment is safe for you to receive the care you need. In return, we ask that you stay home if you are experiencing symptoms of being sick, are sick, or have come in contact with someone who has tested positive for COVID-19.

We have implemented the following in our facility:

1. We have reduced the number of team members in our facility every day. Only essential members will be present.
2. We have increased the cleaning of all our equipment and fixtures, and our team will maintain a safe distance, to the extent practical, from each patient. We ask that you please do the same.
3. We are following the advice of the American Physical Therapy Association (APTA): "The COVID-19 outbreak changes the factors we must consider in our professional evaluation, but it does not change our basic responsibility to do what is best for our patients. PTs should follow their professional judgment to determine when, where, and how to provide care."

During these uncertain and challenging times, we will continue to serve you with the same high level of quality care that you have come to expect from us.

By signing this waiver, you acknowledge we have provided the safest possible environment for your treatment. In consideration of being permitted to participate in the physical therapy services provided by On-Site Physical Therapy, LLC, you agree to assume full responsibility for any risks, injuries or damages, known or unknown, which you may incur related to COVID-19 as a result of participating in our physical therapy services and you, your heirs or legal representatives forever release, waive, discharge and covenant not to sue On-Site Physical Therapy, LLC for any said injuries or damages.

I have read the above release and wavier of liability and fully understand its contents. I voluntarily agree to the terms and conditions stated above.

Signature _____ Date _____
Print Name: _____