PHYSICAL THERAPY & SPORTS REHAB

Patient Information Form

Name:_____ Date of birth_____

Home phone:_____ Cell_____ Email_____

Home address:_____ City:_____ Zip:_____

Physician:_____ Phone:_____

Whom may we contact in case of emergency?_____ Phone_____

How did you hear about us? _____

Receive notifications for upcoming appointments? ☐ Text messaging ☐ Email (we will call you the day before your appointment to confirm otherwise)

This is to certify that I have been given, offered, or have seen the posted copy of the **Notice of Privacy Practices** (also known as HIPAA).

_____ _____

Patient/Guardian signature Date

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information to be true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

_____ _____

Patient/Guardian signature Date

- Was this due to an auto accident? ( ) Yes ( ) No
- Insurance Carrier? _____ Claim# _____
- Date of Accident? _____
- Attorney Name: _____ Attorney Phone: _____

XL
PHYSICAL THERAPY & SPORTS REHAB

Medical History Questionnaire

Name _____ Age _____ Date_____
Please describe your current complaint or limitation:_____
Please explain resulting functional limitation:_____
Please describe how your problem began:_____
Please tell us when your condition started:_____
What was your prior level of function:_____
Circle tests you have had: XRAY MRI OTHER:_____
Did you have surgery: NO YES Date:_____
Please circle the nature of your pain:

Sharp pain Dull ache Burning Constant Intermittent

Tingling Throbbing Numbness Shooting

Medications:_____

Indicate the intensity of your pain at rest: (NO pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable pain)

Indicate the intensity of your pain with movement: (NO pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable pain)

Since this condition began your symptoms have: decreased not changed increased

Your symptoms are worse in: morning afternoon night increased during the day same all day

Activities or positions that increase symptoms:_____

Activities or positions that decrease symptoms:_____

Occupation:_____ Has your work status changed because of this condition? Yes No

If you have ever had a listed condition in the past, please list in PAST column. If you are presently troubled by a particular condition, check in the PRESENT column. The information you provide concerning past and present conditions assists your therapists in more thoroughly understanding your state of health.

Past	Present	
___	_____	High blood pressure
___	_____	Angina
___	_____	Heart attack
___	_____	Stroke
___	_____	Asthma
___	_____	HIV/AIDS
___	_____	Cancer Location_____ Date_____
___	_____	Tumor
___	_____	Systemic lupus
___	_____	Hepatitis
___	_____	Epilepsy
___	_____	Diabetic
___	_____	Rheumatoid Arthritis
___	_____	Arthritis
___	_____	Other _____
___	_____	Tobacco packs/day_____
___	_____	Drug or Alcohol Dependence
___	_____	Osteoporosis/Osteopenia

Hospitalization/Surgical Procedures (list if not described elsewhere):_____

_____

_____

_____

Do you have a pacemaker? Yes___ No___

_____

Patient/Guardian Signature

PHYSICAL THERAPY & SPORTS REHAB

POWER OF ATTORNEY and MEDICAL RELEASE

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PAPER WHICH WILL EXPEDITE PAYMENT TO PROVER FOR SERVICES RENDERED INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS/AUTHORIZATION TO PAY.

Know by all these present that: the undersigned has made, constituted, and appointed, and by these present does hereby make, constitute and appoint **XL PHYSICAL THERAPY & SPORTS REHAB**, and any of its duly authorized agents and employees as and to be the undersigned true and lawful attorney for and in the undersigned's name, place and stead to endorse and all checks, drafts, or money orders which are made payable to the undersigned alone or to the undersigned and the said **XL PHYSICAL THERAPY & SPORTS REHAB**, which checks, drafts, or money orders are made payable for services which have been made by **XL PHYSICAL THERAPY & SPORTS REHAB**, at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft, or money order.

Furthermore, the undersigned allows **XL PHYSICAL THERAPY & SPORTS REHAB**, or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include affidavits of non-ownership of vehicles, insurance forms and other statements.

The undersigned by these presents does give and grant the said **XL PHYSICAL THERAPY & SPORTS REHAB**, as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all interests and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said checks are concerned as well as any other document.

MEDICAL RELEASE

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me to release true copies of same to **XL PHYSICAL THERAPY & SPORTS REHAB,** or any insurer providing coverage to me in connection with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be as binding as an original signature page.

The undersigned does hereby ratify and confirm and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these presents.

Release of information: I hereby authorize this medical provider to furnish my insurance company or companies nd the patient's attorney with any and all information that may be contained in my medical records, to obtain coverage information telephonically from my insurer, to request a written non-redacted PIP payout sheet from the insurer, and to obtain copies of my medical records, including but not limited to, documents, reports, scans, notes, opinions, X- rays, and MRI's received from any other medical provider or any insurance company. The insurer is directed to keep the patient's medical records private and confidential. The insurer is NOT authorized to provide these medical records to anyone, including but not limited to, third party vendors without the patients and the providers prior express written permission.

ASSIGNMENT OF BENEFITS

I,_____Hereby authorize _____ (Name of insured) (Name of Insurance Carrier)

Payable directly to **XL PHYSICAL THERAPY & SPORTS REHAB**

Payable to and mailed directly to **4022 N. Ocean Blvd, Ft. Lauderdale, FL 33308**

The medical benefits otherwise payable to me for their services, but not to exceed the charges of those services. I hereby IREVOCABLY ASSIGN to **XL PHYSICAL THERAPY & SPORTS REHAB** any benefits under policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and/or charges provided by **XL PHYSICAL THERAPY & SPORTS REHAB.** IN WITNESS WHEREOF the undersigned have here unto set their hands this_____day of_____, 20_____

_____ _____

PATIENT/GUARDIAN SIGNATURE PATIENT'S NAME (PLEASE PRINT)

Effective May 1, 2019

XL PHYSICAL THERAPY & SPORTS REHAB

2001 NE 48th Street
Ft. Lauderdale, FL 33308

Patient's Pledge

As a patient of XL Physical Therapy and Sports Rehab, I pledge to…

Contact the office before 7am if I am unable to make my appointment

- I understand that if I do not call to cancel prior to 7am on the day of my appointment, a $40 charge will be applied to my account *for each visit.*

Be on time for my scheduled appointment

- I understand that every arrangement will be made by the staff for me to be seen on time, but I agree not to be more than 15 minutes late. I may be assisted in rescheduling to another day.

Pay with credit card or cash at my first visit

- After my first visit, I will have the option to pay each visit or pay weekly. No patient will be allowed to continue therapy the following week until payments are received.

Pay my balance in full at the time service is rendered to me

- Furthermore, if I have health insurance, I agree to pay any unpaid balance that the insurance company may not have paid after 30 days.

Thank you for your cooperation

_____ _____

Signature Date

_____

Print Name