



FELIPE CARBONELL, DPT
ERIK GONZALEZ, PTA

TONY TERESI, PTA, CPT
MARTHA CAMERON, PT

PH: 941-355-5565 FAX: 941-355-3933

Patient Registration Information (please print):

Birth Date: _____ Age: _____ Sex: M () F () SS # : _____

Name: _____
Last First MI

ADDRESS: _____
Street

City State Zip Code

HOME PHONE: () _____ WORK PHONE: () _____

CELL PHONE () _____ Family Physician: _____

E-Mail: _____

Out-of-town address/phone: _____

Occupation: _____ Employer: _____

Marital Status: _____ Spouse's Name: _____

IN CASE OF EMERGENCY, NOTIFY: NAME: _____

PHONE#: _____ RELATIONSHIP: _____

I authorized Gulf Shore Physical Therapy to leave information regarding my therapy on my

Home phone: yes () no () Work phone: yes () no () Cell phone: yes () no ()
Do you want to receive appointment reminders: yes () no () By text message () E-mail ()
Cell Phone Company _____ E-mail: _____

I authorize this facility to share information regarding my therapy with the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patients Signature: _____ Date: _____

How did you hear about our facility? _____

Medical Information Sheet

NAME: _____ AGE: _____ DATE: _____

Referring PHYSICIAN: _____

WHAT ARE WE SEEING YOU FOR: _____

DATE OF INJURY/SYMPTOMS STARTED: _____

METHOD OF INJURY: _____

HAVE YOU HAD ANY PHYSICAL THERAPY THIS YEAR (IF YES PLEASE SPECIFY WHERE): _____

Have you received any therapy for this condition? _____ If yes, please explain: _____

CHECK ANY MEDICAL CONDITIONS THAT YOU HAVE BEEN TREATED FOR:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Incontinence | <input type="checkbox"/> Cardiac Problems | <input type="checkbox"/> Pacemaker/Defibrillator | <input type="checkbox"/> Joint Replacement (list): |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Neurological Problems | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis/Osteopenia | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Cancer | Type of cancer: _____ | <input type="checkbox"/> Other Surgeries: | <input type="checkbox"/> _____ |
| | Is it current? _____ | | <input type="checkbox"/> _____ |

MEDICATIONS: (If you have a list please provided it at this time):

What was your activity level prior to injury/surgery? Occupational: light moderate heavy N/A
Recreational: light moderate heavy

What is your current activity level? Occupational: light moderate heavy N/A
Recreational: light moderate heavy

Do you have trouble walking? _____ if yes, how far or for how long can you walk without pain? _____

Please review the following list of activities. Do you have trouble performing or are unable to perform any of these tasks? (Check all that apply)

- | | | | | |
|---|--|--|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Getting into/out of bed | <input type="checkbox"/> Eating | <input type="checkbox"/> Getting into/out of chair | <input type="checkbox"/> Sitting | <input type="checkbox"/> Driving |
| <input type="checkbox"/> Walking up/down stairs | <input type="checkbox"/> Walking | <input type="checkbox"/> Work related activities | <input type="checkbox"/> Standing | <input type="checkbox"/> Cleaning |
| <input type="checkbox"/> Bathing/Showering | <input type="checkbox"/> Doing Laundry | <input type="checkbox"/> Vacuuming | <input type="checkbox"/> Cooking | <input type="checkbox"/> Writing |
| <input type="checkbox"/> Getting into/out of shower | <input type="checkbox"/> Shopping | <input type="checkbox"/> Brushing your teeth | <input type="checkbox"/> Sleeping | |
| <input type="checkbox"/> Getting into/out of car | <input type="checkbox"/> Dressing | <input type="checkbox"/> Personal Hygiene activities | <input type="checkbox"/> Shaving | |
| <input type="checkbox"/> Other: _____ | | | | |

What is the location of the pain or discomfort we are seeing you for?

Please check if your pain/discomfort is:

- Constant Occasional
Since initial injury/onset, has your pain:
 Improved Worsened

PLEASE RATE YOUR PAIN ON A SCALE OF 0 – 10.

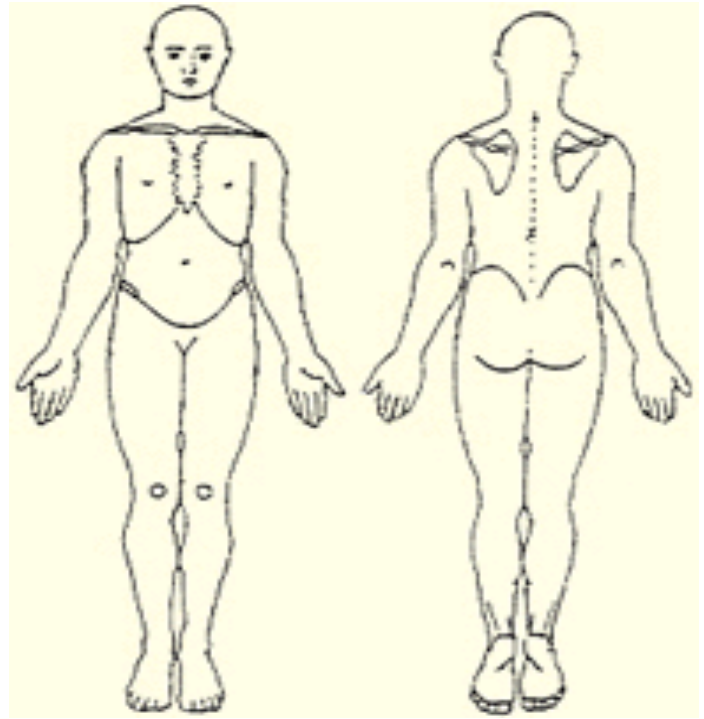
(0 = No Pain, 10 = The Most Pain Imaginable)

0 1 2 3 4 5 6 7 8 9 10

What makes your pain better? _____

Worse? _____

Signature: _____



*Please use the body chart above to indicate the location of your symptoms:
XXX = PAIN OOO = NUMBNESS*



FELIPE CARBONELL, DPT
ERIK GONZALEZ, PTA

TONY TERESI, PTA, CPT
REBECCA OVERDORF, DPT

PATIENT NAME: (Please Print) _____

Thank you for placing your confidence in us by choosing us to provide for your rehabilitative needs. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

AUTHORIZATION FOR TREATMENT:

I hereby authorize Gulf Shore Physical Therapy & Performance Center, Inc., through its appropriate personnel, to perform on me (or the above named patient) appropriate assessment and treatment procedures relating to my diagnosis.

RELEASE OF INFORMATION:

I hereby authorize Gulf Shore Physical Therapy & Performance Center, Inc. to release to my physician, insurance company, attorney and/or other appropriate parties, any information acquired in the course of my (or the above named patient's) treatment.

ASSIGNMENT OF INSURANCE BENEFITS/DIRECT PAYMENT:

I authorize my insurer to pay any benefits directly to Gulf Shore Physical Therapy & Performance Center, Inc. I agree to pay Gulf Shore Physical Therapy & Performance Center, Inc. the full and entire amount of all bills incurred by myself or the above named patient to include any amount due after payment has been made by my insurance carrier.

INSURANCE DEDUCTIBLES, CO-INSURANCES & CO-PAYMENTS:

Medicare and your commercial insurances reviews our charges and expenses on an ongoing basis in order to ensure that they are fair and competitive. We will file your Medicare or Primary insurance claims and also (if you wish) your supplement insurance claims.

YOU ARE RESPONSIBLE FOR CO-PAYMENTS, CO-INSURANCES, and PAYMENT OF YOUR YEARLY DEDUCTIBLE IF IT HAS NOT BEEN MET OR COVERED BY YOU OR YOUR SUPPLEMENTAL INSURANCE PLAN.

IT IS YOUR RESPONSIBILITY TO VERIFY BENEFITS AND COVERAGE OF YOUR INSURANCE PLAN PRIOR TO START OF YOUR THERAPY SESSIONS.

Gulf Shore Physical Therapy has an ongoing credit policy for our clients. Our terms are net 30 days. Late charges of 15% per month will be assessed on past-due accounts, and collection charges and/or attorney fees may be added. Interest free payments plans are available upon request on a case by case basis.

**** Please note: our corporate name is Fisico Therapy Solutions, LLC. We do business as Gulf Shore Physical Therapy. Our corporate name may be shown on your explanation of benefits. ****

APPOINTMENTS:

**Our time is reserved just for you. We require a 24/hrs. notice. Failure to do so will result in a \$25 fee.
Appointments are subject to mandatory rescheduling if patient is 15 or more minutes late.**

Thank you.

By signing below, I acknowledge that I received the Notice of Privacy Practices and have had an opportunity to read it. It is posted on the wall and you can request a copy for your records at the front desk at any time.

PATIENT SIGNATURE (or responsible person): _____ **DATE:** _____

PARENT OR LEGAL GUARDIAN (if applicable) _____ **DATE:** _____

OUR STAFF LOOKS FORWARD TO WORKING WITH YOU. OUR GOAL IS TO MAKE YOUR REHABILITATION BOTH PLEASANT AND SUCCESSFUL!



24 Hour Cancellation and “No Show” Fee Policy

Gulf Shore Physical Therapy is now enforcing our Cancellation/No Show policy which states:

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Gulf Shore Physical Therapy Center reserves the right to charge a fee of \$25 for all missed appointments (“No Show”) that are cancelled without a 24-hour advance notice.

“No Show” fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple “No Shows” in any 12 month period may result in termination from our practice.

Appointments are subject to mandatory rescheduling if patient is 15 or more minutes late.

Thank you for your understanding and cooperation as we strive to give the best service and meet the needs of all of our patients.

Signature: _____

Date: _____



8331 Lockwood Ridge Road
Sarasota, FL 34243
Phone: (941) 355-5565

Dear Patient:

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT.

We now offer the following Payment Options:

- Payment by cash
- Payment by check
- Payment by credit card
- Automatic monthly billing to your Visa or MasterCard (Payment Plan Option).
- Guarantee any amount not covered by insurance with Visa or MasterCard (Payment Plan Option).

Please make your choice, sign below and return to office manager before treatment.

Our office is a fully approved and accredited user of the *Visa and MasterCard Health Care Program* which will enable you to use your Visa and MasterCard to automatically cover amounts not paid by your insurance.

You may also choose a comfortable amount to be automatically billed to your Visa or MasterCard on a monthly basis.

If none of the above apply, please see the office manager. Thank you.

Print your name here and sign below

x _____

Date: _____



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Corona Virus 19 Questionnaire:

1. Have you recently traveled to an area with known local spread of COVID-19?

Circle: YES NO

2. Have you come into close contact (within 6 feet) with someone who has a laboratory confirmed COVID-19 diagnosis in the past 14 days?

Circle: YES NO

3. Do you have a fever (greater than 100.4 F or 38.0 C) OR symptoms of lower respiratory illness such as cough, shortness of breath, difficulty breathing or sore throat?

Circle: YES NO

Our new policies are for all patients are required to:

- **Wear masks** when in the facility, if you do not have one we will provide one. Please bring it with you to each session.
- Use the **hand sanitizer** when you arrive before signing in and when you leave the facility.
- Your therapist will be taking your temperature before your session starts.
- If you are considered "At-Risk", you will need clearance from your doctor to start therapy.
- Our waiting room is for **patients only**, everyone else will be asked to wait in their cars.

The CDC and our clinic is recommending that if you are 65 or older and/or have any of the following conditions, to pause therapy at this time or postpone the start of your therapy until cleared by your doctor. Examples of serious underlying medical conditions are as follows, but not limited to:

- Moderate to Severe:
- Heart Disease
- Diabetes
- Lung Disease
- Immunocompromised
- Asthma

By signing below, I agree and understand the risk factors in participating in treatment for physical therapy at Gulf Shore Physical Therapy Center and that Gulf Shore Physical Therapy Center and its clinicians will be released of any liability related to COVID-19.

Printed Name

Signature

Date