ANTOINETTE OHLSON, PT TONY TERESI, PTA, CPT CHRISTOPHER SAYLOR, DPT

ERIK GONZALEZ, PTA DANIELLA CASTROGIOVANNI, PTA

Patient Registration Information (PLEASE PRINT)

Birth Date: ____________________ Age: _____ Sex: M ( ) F ( ) ____________________

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 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? ____

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

Medical Information Sheet

NAME: ________________ **AGE:** ________ DATE: ____________

Height: __________ **Weight:** __________

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:

- ☐ Incontinence
- ☐ Circulatory Problems
- ☐ Stroke
- ☐ Cancer Type of cancer: __________ Is it current? __________
- ☐ Cardiac Problems
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Pacemaker/Defibrillator
- ☐ Neurological Problems
- ☐ Osteoporosis/Osteopenia
- ☐ Other Surgeries:
- ☐ __________
- ☐ Joint Replacement (list):
- ☐ __________
- ☐ __________

Are you a tobacco user: Yes: ______ No: ______

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

____

____

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

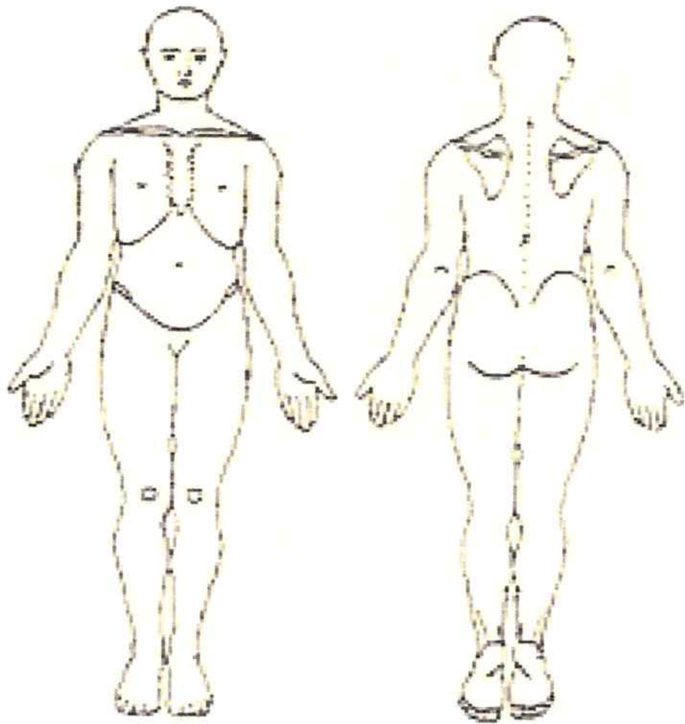
What is your current activity level?
Occupational: ð light ð moderate ð heavy ð N/A
Recreational: ð light ð moderate ð heavy

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)

- ☐ Getting into/out of bed
- ☐ Walking up/down stairs
- ☐ Bathing/Showering
- ☐ Getting into/out of shower
- ☐ Getting into/out of car
- ☐ Eating
- ☐ Walking
- ☐ Doing Laundry
- ☐ Shopping
- ☐ Dressing
- ☐ Getting into/out of chair
- ☐ Work related activities
- ☐ Vacuuming
- ☐ Brushing your teeth
- ☐ Personal Hygiene activities
- ☐ Sitting
- ☐ Standing
- ☐ Cooking
- ☐ Sleeping
- ☐ Shaving
- ☐ Driving
- ☐ Cleaning
- ☐ Writing
- ☐ 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

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

What makes your pain better?________________________________

Worse? ________________________________

Signature:____

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 Fisico Therapy Solutions, LLC dba Gulf Shore Physical Therapy Center 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) treatment.

ASSIGNMENT OF INSURANCE BENEFITS/DIRECT PAYMENT:
I authorize my insurer to pay any benefits directly to Gulf Shore Physical Therapy Center. I agree to pay Gulf Shore Physical Therapy Center 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. If I opt out of using my insurance, I agree to pay Gulf Shore Physical Therapy Center the full and entire amount of all bills incurred by myself (or the above-named patient) to include any amount due at time of service as agreed upon at initial evaluation.

INSURANCE DEDUCTIBLES, CO-INSURANCES & CO-PAYMENTS:
Medicare and your commercial insurance companies review] 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. ***

**** 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 from your Insurance Company. ****

APPOINTMENTS:
Our time is reserved just for you. We require a 24 hour. notice for cancellations.
Failure to do so will result in a $50.00 late cancel fee. No Show Fee is also $50.00
Appointments are subject to mandatory rescheduling fee if patient is later than 15 minutes.
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:** ______________

GULF SHORE
Physical Therapy Center

5899 Whitfield Ave, Suite 100
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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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 $50.00** 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**:_______________