Bayside Physical Therapy Patient Information:

Legal name: First Name _______________ Middle Initial___ Last Name___________________________

Any nickname or shortened name you prefer to go by?____

Date of Birth Month__________ Day___ Year____________ Social Security #______________________

Mobile phone number with area code: ______________________ Home phone______________________

Email address: _________________________________ ________________Gender______________________

Street address____________________________________ City_______________ State____ Zip___________

Employer:____________________________________ Occupation___________________________________

Referred by Florida Physician (name)____

Or referred by other____

Name of emergency contact___________________ Relationship________ Phone #__________________

Allergies or medical precautions____

Signature____ Date___________________

Insurance Information: present insurance card(s) to receptionist to skip this section

Primary Insurance______________________Policy#__________________________Group #_____________

Insurance company address____

*Insured's info- Name*________________________ *SS#*______________________ *Date of birth*____________

*Policy Holder's name*____________________________ *Relationship to patient*_________________________

Secondary Insurance__________________ Policy #__________________________ Group #______________

Insurance company address____

*Insured's info- Name*________________________ *SS#*______________________ *Date of birth*____________

*Policy Holder's name*____________________________ *Relationship to patient*_________________________

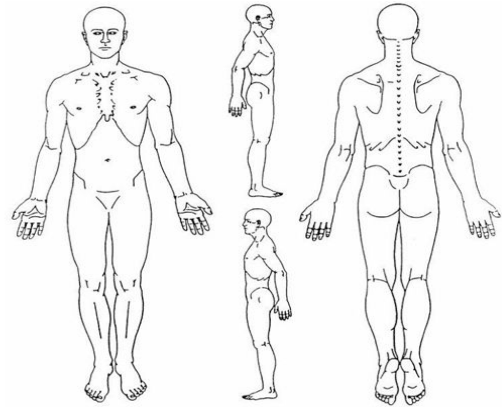
Symptoms Questionnaire for Bayside Physical Therapy

Legal Name __________________________Date of Birth___________Age____ Right or Left Handed____

What is your main complaint? ____

____

Indicate on the body pictures where your pain or problem is located:



Also indicate on the pictures any specific areas of numbness, tingling, burning or shooting pain.

When and how did this current problem begin? ____

____

What makes your symptoms/pain worse? ____

____

What decreases your pain/symptoms? ____

____

Are your symptoms worse (circle) in the morning / afternoon / evening /during the night / inconsistent

Overall, are your symptoms (circle) improving / worsening / unchanged / inconsistent

Pain Scale –use this scale of numbers (no pain 0 1 2 3 4 5 6 7 8 9 10 extreme pain) for the following:

Now_____

Worst it has been today____ What provoked that?_______________________________________

Worst it has been in the last 7 days____ What provoked that?_____________________________

Best it has been today____

Medical History for Bayside Physical Therapy

	Never	Previously	Yes, currently
Diabetes			
Heart problems			
High blood pressure			
Breathing Problems			
Cancer			
Osteoporosis			
Fracture			
Neck injury			
Back injury			
Seizures			
Pregnant			

Any other illnesses, body conditions or past injuries we should be aware of? ________________________

____

What surgeries have you had? ____

____

Have you had physical therapy already in this calendar year? _____ If so, where? ___________________

Have you had any special tests for this problem (circle)? X-ray /MRI / CT Scan / other________________

Have you had other treatments for this? (circle) injections/massage/medications/Chiropractic/other

List what problems you are currently taking medication for:______________________________________

____

Can you fully take care of yourself currently?____ Does anyone else live with you in your home?______

Do you have stairs at home? ___ About how many? ____________ Is there a handrail?_____________

Can you get in and out of a car easily? _________Are you able to drive?____________________________

Marital status (circle) Single Married Separated Divorced Widowed Other

Is this problem related to a work injury or auto accident or some other fault?

If so, is there an attorney involved in this case?____ Attorney name/firm___________________

Are you presently working?________ If retired, from what and since when?______________________

What would you like to achieve in physical therapy?_________________

CONSENT FORM FOR EVALUATION & TREATMENT AT BAYSIDE PHYSICAL THERAPY

I acknowledge and understand that I am coming to Bayside Physical Therapy for evaluation and treatment of a body condition.

In order for ongoing physical therapy treatment to be effective, I understand that I must come to scheduled appointments (unless there are unusual circumstances), follow recommendations, and complete the home program intended for me. If I have questions about or trouble with any part of my treatment program, I will discuss it with my physical therapist.

NO WARRANTY: I understand that there are no guarantees for improvement in my condition. I understand that if I am uncomfortable with the assessment or treatment procedures at any time, I will inform my therapist and alternatives will be discussed with me.

CONSENT FOR THERAPEUTIC USE OF DIGITAL IMAGES AND VIDEOS: I give Bayside Physical Therapy permission to take photographs and videos of me for purposes such as documenting baseline function, functional progress, movement re-education and education on home exercises. I understand that these photographs and videos will not be used for any purpose beyond my medical care without my expressed written consent.

Date: ________

Patient Name (Printed) ___________________________

**Patient Signature:____________________________________

Also, if under age of 18, signature of parent or guardian____

ATTENDANCE POLICY

Bayside Physical Therapy strives to provide you with the highest quality of care while attempting to accommodate to your convenience and to your schedule. We work hard to ensure continuity of your treatment for optimized progress. Your consistent attendance in accordance with your therapist's instructions will lead to a more rapid recovery.

While we are sensitive to the fact that an emergency might cause you to miss an appointment or to change the appointment at the last minute, we must insist on keeping such occurrences to an absolute minimum.

As such, we reserve the right to charge a $20 cancellation fee per occurrence if less than 24 hours cancellation notice is given before a scheduled appointment. The fee gets charged to you personally, not your insurance company. Your cooperation is greatly appreciated.

I have read and agree to abide by the above attendance policy.

**Signature___________________________________ Date_____________

Bayside Physical Therapy

1001 S Ft Harrison Ave Suite 101, Clearwater FL 33756

Financial Policy, Release and Authorization

AUTHORIZATIONS: I authorize Bayside Physical Therapy (doing business as Bayside Urgent Care Center) to bill my insurance company directly, and I authorize payment of benefits directly to Bayside Physical Therapy dba Bayside Urgent Care Center. I authorize the release of medical or other information necessary to process this claim. I understand that I am ultimately responsible for my physical therapy charges, and I agree to pay my deductible, my co-insurance or co-payment and any other charges not covered by my insurance carrier. I understand that some insurance companies require medical or administrative pre-authorization for treatment, and that some have reimbursement limits on physical therapy expenses. I understand that I am responsible for knowing and meeting the requirements of my insurance plan.

REGARDING INSURANCE: Insurance is a contract between you and your insurance carrier. We strongly encourage you to contact your insurance carrier to determine what coverage they provide for physical therapy. We cannot guarantee what your insurance carrier will pay. We file insurance claims as a courtesy to our patients. You must provide all necessary information to assist us with your billing. We will not become involved in disputes between you and your insurance carrier regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary charges", etc, other than to supply factual information necessary. Some medical equipment and supplies may not be covered in your insurance plan, so you may be responsible for any such purchases. You are responsible for timely payment of your account.

HMOS/PPOS: If you are covered by these types of insurance, your co-pay is due at the time of service.

MEDICARE: We are providers for Medicare and we will take the responsibility of submitting your claim for you. We will bill your secondary insurance if applicable. However, you are responsible for the deductible if it has not been met at the time of service, and for the co-insurance if you do not have a secondary insurance policy.

WORKERS COMPENSATION, AUTO ACCIDENTS AND PERSONAL INJURY: If you have been injured in one of these situations, please inform us before you set up your appointment since pre-arrangements are often necessary.

SELF-PAY: Payment is due at time of service. We accept cash, check, Visa, MasterCard, or American Express. Payment plans may be requested if needed.

I understand and accept the conditions of this financial policy.

Printed Legal Name____

Signature____ **Date**_______________

Bayside Physical Therapy

1001 S Ft Harrison Ave Suite 101 Clearwater, FL 33756

Written Acknowledgment of Receipt of Notice of Privacy Practice

Insert Legal Adult Name:

I, __________________________ hereby acknowledge that I have received and/or viewed a copy of The Notice of Privacy Practices.

Adult Signature_____________________   Date____________

If patient is under the age of 18, what is the relationship to the adult who signed this?

Specific Consent for Release of Information

I give my consent for Bayside Physical Therapy (doing business as Bayside Urgent Care Center) to call, text, email or mail my home or other designated people/locations. Bayside Physical Therapy may also leave a message on voicemail or discuss with designated persons about appointments, evaluation findings, treatment data, and/or insurance issues pertaining to my clinical care.

Besides me, only the following individuals or offices may have access my physical therapy information:

Name	Relationship
__________________________	________________________
__________________________	________________________

Signature_______________________________   Date________________