



Welcome to Physical Therapy Professionals, LLC

Our team of qualified professionals is happy to assist you throughout the rehabilitation process. Our staff is committed to exceeding your expectations and we are confident that we can make your recovery a positive experience.

Your Viera Staff

Christine
Office Staff/Patient Intake

Mary Kate
Office Staff/Patient Intake

Dr. Laura Siviter, PT, DPT
Physical Therapist
Manual Therapy Certified
Director of Operations

Nancy Figulski, PT
Physical Therapist
Certified McKenzie
Therapist

Dr. Laura Kaufman, PT, DPT
Physical Therapist

Shardae Clemens, PTA
Physical Therapy Assistant

Andrea O'Buck
Billing Specialist

Your Palm Bay Staff

Bernadette
Office Staff/Patient Intake

Dr. Kim Yancey, PT, DPT
Physical Therapist

Dr. Jessica Ford, PT, DPT
Physical Therapist

Randal Brown, PT, MSPT
Physical Therapist

Your Administrators

Dr. Daryl Jacobs, PT, DPT, ATC
Physical Therapist
Manual Therapy Certified
President/CEO

Dr. Shauna Jacobs, PT, DPT
Physical Therapist
Manual Therapy Certified
Vice President/CFO



First Name: _____

Last Name: _____ MI: _____

Preferred Name: _____

Sex: MALE / FEMALE / DECLINE TO ANSWER

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: ____/____/____ Social Security Number: ____ - ____ - ____

How did you hear about Physical Therapy Professionals? _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

For billing purposes if you have an alternate address please list below. Please include the date range that you normally reside at this secondary address:

Address: _____

City: _____ State: _____ Zip: _____ Dates: _____

Please provide your email address below to avoid charges for mailing requested medical records and / or outstanding financial statements. To ensure your privacy all email will be sent over a secure network and your address will not be shared publicly to any third party. If you have questions in regards to the above, please see the receptionist.

Email address: _____

I understand and agree that I am responsible for the balance of my account for any services rendered. I have read all the above information and the information provided is true and correct to the best of my knowledge. I will notify Physical Therapy Professionals of any changes with the above information. I hereby authorize any treatment(s) agreed upon with my physical therapist and my referring provider (if applicable) that are deemed medically necessary.

Patient Signature: _____ Date: ____/____/____



Patient Name: _____ DOB: _____

Consent for Treatment

I, the undersigned do hereby agree and give my consent for Physical Therapy Professionals, LLC to furnish medical care and treatment which is considered necessary and proper in the diagnosing or treating of my physical conditions.

Signature _____ Date _____

Benefit Assignment/ Release of Information

I, the undersigned, hereby assign all medical benefits, i.e.: Medicare, Private insurance, major medical benefits, Worker’s Compensation and any other health plans to which I am entitled to Physical Therapy Professionals. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize Physical Therapy Professionals to release all medical information and records necessary to secure payment for services.

Signature _____ Date _____

Financial Policy Statement/ Insurance Verification

Primary Insurance Carrier: Policy#
Deductible: \$ \$ has been met
Copay/ Coinsurance: \$
Secondary Insurance Carrier:

Comments: You will be responsible for a (\$) copay for the initial visit and a (\$) per visit until deductible has been met. After that, you will be responsible for a (%) coinsurance until the out-of-pocket maximum has been met. After that, your insurance quotes that you will be covered at 100%.

By initialing here, you are acknowledging that the amount being collected IS AN ESTIMATE and you may owe more/less depending on how your insurance processes our claims. PATIENT WILL BE RESPONSIBLE FOR ANY CHARGES NOT COVERED BY THEIR INSURANCE. If an over-payment has occurred, you will receive a refund check once all claims have been processed. Initials: _____

PT Professionals will bill your insurance company as a courtesy to you. In most cases, we have an agreement with your insurance company to handle payments for your physical therapy. If your insurance company does not remit payment within 60 days from the date submitted (a universally accepted time period), PT Professionals reserves the right to collect the full balance from you. The above information may not apply to those receiving Worker’s Compensation benefits. However, be advised if you claim Worker’s Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you .I understand and confirm that if I fail to make any of the payments for which I am responsible in a timely fashion, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and/or attorney fees. I give consent to PT Professionals to treat me for this condition, and I understand my responsibility for the payment of my account. I have read the above information and/or it has been explained to me and I accept the terms and conditions of the above and will be responsible for payment of my account.

Signature _____ Date _____



Cancellation Policy

We have multiple methods available to remind you of your appointments and it is your responsibility to attend scheduled appointments. Late notice cancellations or no shows harm our practice and will likely affect your recovery. If you fail to attend a scheduled appointment or cancel with less than 24-hour notice, any future no show or late notice cancellations will result in all future appointments being deleted. A \$50 no-show fee will be charged before additional appointments can be scheduled and will be also be charged for any future missed visits without proper notification. Initials: _____

Home Health

Most insurance companies will not cover out-patient physical therapy if you are receiving Home Health Care of any kind at the same time. **By initialing below, you indicate that you are currently not receiving any type of home care** including nursing, occupational therapy or physical therapy from a Home Health Agency. It is also your responsibility to inform us if you initiate home health care for any reason during the course of your treatment with us or you will be responsible for any denied payments that result from concurrent treatments. Initials: _____

Acknowledgement of Receipt of Notice of Privacy Practices

This facility will make every attempt to protect your privacy and personal information. We have provided a summary of your rights and protections under the federal health information privacy law. We would like to retain your signature to acknowledge the receipt of our notice of privacy practices.

You will receive a copy of the Privacy Practice Notice on your first appointment

I have received a copy of the notice of privacy practices at PT Professionals.

Initials: _____

Option to Give Access to Medical Records

I authorize _____ (Examples: Spouse, Sibling, Parent, Caregiver) access to medical information pertaining to my treatment. Please note that PT Professionals will not share your information with any individual that are not involved with your case unless you specify otherwise.

Please note that if you are 18 years or older, we cannot release your information to any other individual that does not have a business associate agreement with PT Professionals and is not directly involved with your case unless you otherwise specify.



Appointment Reminder Notifications

Would you like to receive free appointment reminder notifications via text message, phone call or e-mail message?

Text Message (Phone Number): _____

Phone Call (Phone Number): _____

Email (Email Address): _____

No Reminders

Email Newsletter

Would you like to be included on our email list to receive our newsletter and updated clinical information and health tips from PT Professionals?

Email: _____

Not Interested

DISCLAIMER

We will not use this information for any other purpose than to contact you via the PT Professionals mailing list & PT Professionals contact list. We WILL NOT pass your email address, phone number or other information to other companies. You may at any point have your details removed from our database by contacting our webmaster.

Patient Name: _____ Referring practitioner: _____

Is this a Work-related Injury? Yes No Is this related to an Auto Accident? Yes No

Is there an attorney involved in this case? Yes No

Have you had surgery for this condition? Yes No If yes, date: _____

Have you received previous treatment for this condition? Yes No If yes please describe: _____

Are you a previous patient of PT Professionals? Yes No

Are you currently receiving or have you received in the last 30 days any home health, medical or chiropractic services rendered to you by any other agency? Yes No If yes, please describe: _____

Are you currently taking any medications **for this injury**? YES NO

Anti Inflammatories Muscle Relaxers Pain Medication Other: _____

At the present time, would you consider your overall health:

EXCELLENT VERY GOOD FAIR POOR

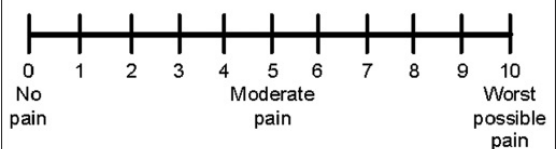
Females: Are you currently pregnant? YES NO

Do you now have, or have you ever had any of the following?

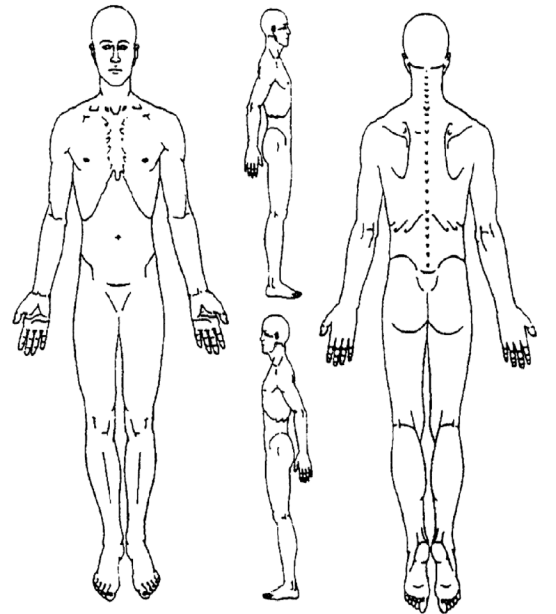
Pacemaker and/or defibrillator	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Diabetes	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Coronary Artery Disease/Angina	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Shortness of Breath/Chest Pain	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Heart Attack/Heart Surgery	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Latex Sensitivity/Allergy	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Blood Clot	<input type="checkbox"/> YES	<input type="checkbox"/> NO
High Blood Pressure	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Osteoporosis	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Pin/Metal Implants	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Asthma, Bronchitis or Emphysema	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Headaches	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Dizzy Spells/Fainting	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Stroke/TIA	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Thyroid Trouble/Goiter	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Joint Replacement	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Infectious Disease (explain below)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Arthritis	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Sleeping Problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you Smoke?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Numbness/Tingling	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Weakness	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Unexplained Weight Loss/Gain	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Hernia	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Epilepsy/Seizures	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Recent changes in Bowel/Bladder	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Allergies:	_____	
Cancer (Please Explain):	_____	

On a scale of 0-10,
(0 being no pain and 10 being at its worst)
Please rate your pain at best ____ at worst ____

0-10 Numeric Pain Rating Scale



Please mark the areas on the diagram below
where you feel the pain.



Please list any other health conditions:

Patient Signature: _____

Date: _____

Patient Name: _____ D.O.B: _____

Medication List

*** This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications name, dosage, frequency and route of administration***

Medication	Dosage	Frequency	Administration Method

I am not taking any Medications at this time.

Patient Signature: _____ Date: _____