

Confidential Medical History/Evaluation



Physical Therapy... the Neapolitan way

Date: ___/___/___
Name: _____ Date of Birth: ___/___/___ Age: ___ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Other Address: _____ City: _____ State: _____ Zip: _____

Male Female ; Marital Status: S M D ; Home Phone: _____ Cell Phone: _____

Insured Employer: _____ Phone: _____ Occupation: _____

Referring MD: _____ Phone: _____ Student: Y N School: _____

Primary Insurance Company: _____ Secondary Insurance Company: _____ Is this injury? Work Related or Auto

Emergency Contact Person: _____ Relationship: _____ Phone: _____

How did you hear about us: Doctor, Insurance Co., Friend, Yellow Pgs, TV, Event, Ad, Other: _____

List any/all medications you are currently taking: _____

List any prior surgeries: _____

Chief Complaint: _____ Date of Injury: _____ Surgery Date: _____

Have you had any Diagnostic or Rehabilitative Services for this Injury? MRI Xrays Other: _____

Do you have any of the following?	YES	NO
Asthma, Bronchitis or Emphysema	_____	_____
Shortness of Breath/Chest Pain	_____	_____
Coronary Heart Disease	_____	_____
Do you have a Pacemaker	_____	_____
High Blood Pressure	_____	_____
Heart Attack/Surgery	_____	_____
Stroke/TIA	_____	_____
Blood Clot/Emboli	_____	_____
Epilepsy/Seizures	_____	_____
Thyroid Trouble/Goiter	_____	_____
Anemia	_____	_____
Infectious Disease	_____	_____
Diabetes	_____	_____
Cancer or Chemo/Radiation	_____	_____
Arthritis/Swollen Joints	_____	_____
Osteoporosis	_____	_____
Varicose Veins	_____	_____
Gout	_____	_____
Sleeping Difficulties	_____	_____
Emotional/Psychological Problems	_____	_____
Bowel or Bladder Problems	_____	_____
Severe/Frequent Headaches	_____	_____
Vision/Hearing Difficulties	_____	_____
Dizziness or Faintness	_____	_____
Are you pregnant?	_____	_____
Smoking	Daily _____ Weekly _____	_____
Alcohol Consumption	Daily _____ Weekly _____	_____
Other Medical Conditions	_____	_____

PAIN SCALE RATING
Pain Scale: Rank your pain on a scale from 0 - 10.
(0=no pain <----->10- "call 911")
Currently: ___/10, at best: ___/10, at worst: ___/10

Draw on the picture below where you feel your symptoms.

Condition:

New
 Acute
 Chronic

Symptoms:

Pain
 Numbness
 Stiffness
 Weakness

FRONT **BACK**

Describe your Chief Complaint:

Are you aware of your Diagnosis? YES ___ NO ___ Are you aware of your Prognosis? YES ___ NO ___

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize release of payment directly to Pelican Sports and Rehabilitation regardless of participation in or out-of-network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred.

Patient/Parent/Guardian Signature: _____ Date: _____

I acknowledge that I have seen the "Notice of Privacy Practices." I understand that I may ask questions about the "Notice of Privacy Practices" at any time.
Patient/Parent/Guardian Signature: _____ Date: _____



IF YOU WERE REFERRED BY YOUR DOCTOR...

WHEN DO YOU SEE YOUR REFERRING DOCTOR AGAIN?

PLEASE HELP US GET YOUR REASSESSMENT REPORT TO YOUR DOCTOR ON TIME, BY ANSWERING THE FOLLOWING QUESTIONS AND LETTING US KNOW IF ANYTHING CHANGES IN THE FUTURE.

YOUR NAME: _____

YOUR REFERRING DOCTOR'S NAME: _____

DO YOU HAVE A DOCTOR'S APPOINTMENT SCHEDULED?

_____ YES

DATE: _____ TIME: _____

_____ NO

_____ I WILL BE CALLING FOR AN APPOINTMENT

_____ DOCTOR'S OFFICE WILL CALL ME FOR AN APPOINTMENT.

_____ MY DOCTOR STATES I DON'T NEED TO COME BACK UNLESS THERE IS A PROBLEM

PLEASE NOTIFY YOUR THERAPIST WHEN YOUR APPOINTMENT IS SCHEDULED OR IF YOUR APPOINTMENT DATE OR TIME CHANGES.

THANK YOU!

PELICAN SPORTS & REHAB

FINANCIAL POLICY

PSR (Pelican Sports & Rehab) will file all insurance claims for our patients.

PSR will attempt to verify each patient's insurance coverage, benefits, and eligibility. We will advise each patient of the coverage determination, copay amounts, and limitations on physical therapy coverage provided by the patient's insurance carrier.

Patients are responsible for providing current and correct insurance information at the first office visit. Patients are responsible for notifying PSR of any changes in their insurance coverage.

Patients are responsible for payment at the time of service of their office copay.

PSR will make every effort to collect from the patient's insurance carrier. However, the patient is ultimately responsible for all charges incurred.

Self-pay patients are welcome at PSR. Payment is expected at the time of service.

If a patient has financial difficulties, PSR will make every effort to set up a mutually beneficial payment plan.

If you are unable to make a scheduled appointment, please call to cancel at least 24-hours prior to the scheduled time. We reserve the right to charge a \$50 no-show fee.

A SPECIAL NOTE TO OUR MEDICARE PATIENTS:

For 2008, the Medicare annual cap for physical/speech therapy is \$1810. After the \$1810 cap has been met, the patient is responsible for payment at our self-pay rate. There are exceptions to this regulation but they are rare. Please let us know if you have had other physical or speech therapy during this calendar year.

Should you have any questions, please do not hesitate to talk to the office manager.

Your signature below indicates that you have **read and understand** our financial policy.

Signature

Date

**PELICAN SPORTS & REHAB
CONSENT & RELEASE**

I, _____ agree to have **Pelican Sports & Rehab** provide physical therapy service to me.

PSR will file all insurance claims for our patients.

PSR will verify each patient's insurance coverage, benefits & eligibility. You will be advised of coverage determination and copay amounts.

You are responsible for providing current & correct insurance information. You are responsible for notifying **PSR** of any changes in coverage.

Patients are responsible for payment at the time of service for copay and self pay.

PSR will make every effort to collect from your insurance carrier. The patient is ultimately responsible for all charges incurred.

Scheduled appointments should be cancelled 24 hours in advance. If you are more than 15 minutes late for treatment, your appointment will be cancelled.

If you miss two consecutive appointments without calling to cancel, all appointments will be cancelled.

I also consent to the release of my medical records from **Pelican Sports & Rehab** to my physician, insurance company and/or attorney confirmed to represent me in legal action.

Signed: _____

Date: _____

Witnessed: _____

PELICAN SPORTS AND REHAB

We would like to continue providing you the best care in Florida!

Mike is going to be sending out interesting and useful healthcare information by email on a monthly basis.

We will need your email address. Please print your name & email address below and give to Peggy. We will add you to our mailing list, and you will hear from us shortly!

Name

Email address

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