13801 Bruce B. Downs Blvd., Suite 303 • Tampa, Florida 33613 • Telephone (813) 979-4819

PRO-ACTIVE PHYSICAL THERAPY

Patient Name: ______________________________ Phone: __________ Cell: _________

Address: ____

City: ______________________________ State: ____________ Zip: _____________

SS#:_____________________ Date of Birth: __________ Age: _______ Sex: _________

Employer Name & Address: ____

Phone: ____________________ Occupation: __________________ How Long: ________

Spouse Name: ____________________________SS#:____________ Date of Birth: _____

Spouse Employer: ______________________________________ Phone: _____________

In case of Emergency, someone we can contact that is outside of your home:

____

Name Address Phone

What part of body is to be examined? ____

If this is an injury, when and how did it occur? _________________________________

____

If not an Injury, when did you start having trouble? ____________________________

Have X-Rays been taken? __________ Date taken & where: ________________________

Have you had any treatment for this injury? ______ by whom? ____________________

Do you have a history of pain or injury to this area in the past, if Yes, please describe: ______________

____

Any known illnesses of: Spinal Cord Injury, Heart, Lung, Diabetes, Vision, Stomach, Nervous Disorder, High Blood Pressure, Ulcers, Cancers, Hearing, Blood Disorder.

If so, please indicate: ____

Please list any previous Surgery: ____

Please list any Medications you are currently taking: ___________________________

____

List any ALLERGIES to Medication: ____

Who is your Family Physician? ____________________________ Phone: ______________

Any possibility of pregnancy? ___________ Height: _____________ Weight: ___________

With which Hand do you write? Left Right

Is a report necessary for an Attorney or Insurance Company, if Yes, Name & Address:

____

Who referred you to this office? ____

SIGNED: ____ DATE: ________________

13801 Bruce B. Downs Blvd., Suite 303 • Tampa, Florida 33613 • Telephone (813) 979-4819

PRO-ACTIVE PHYSICAL THERAPY

Dear Member:

Your contract provides for benefits to be coordinated with other medical insurance by which you may be covered. The primary carrier pays first when there is more than one insurance company or health care provider. Please complete Sections 1 and 2 of this form.

SECTION 1

Is the reason for your visit due to an injury caused by an accident? _________________________

AUTO HOME SCHOOL OTHER: ___________________

Date of accident: ____

How and where did the accident occur? ____

____

Was a third party responsible for your injury? ________ If so, please provide the following info:

Name of individual or company: ____

Name and address of attorney representing third party: ___________________________________

____

Claim and Adjustor information: ____

SECTION 2

(information to be filled out if auto accident)

Were you in your own vehicle or someone else's? _______________________________________

Name of Insurance Company: ____

Were you the driver or passenger? ____

Were you wearing a seat belt? ____

Signature: ____ Date: ______________________

13801 Bruce B. Downs Blvd., Suite 303 • Tampa, Florida 33613 • Telephone (813) 979-4819

PRO-ACTIVE PHYSICAL THERAPY

CANCELLATION POLICY

Please be advised that Pro-Active Physical Therapy will charge a fee for any missed appointments and/or cancelled appointments without 24 hours prior notice. In the event you are unable to make your scheduled appointment time and wish to cancel, kindly give us 24 hours notice. If unable to give proper notice, you, the patient, will be charged $25.00. Your insurance company is not responsible for any appointments you are unable to make without proper notice.

I, the undersigned, do hereby acknowledge the above policy and understand that I will be charged a $25.00 fee for any appointments I am unable to make without proper notice.

________________________________ ________________________________

Patient/Responsible Party **Date**

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of protected health information (*PHI*). The individual is also provided the right to request confidential communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (*check all that apply*)

☐ Home Telephone ___________________

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication

- ☐ O.K. to mail to my home address
- ☐ O.K to mail to my work/office
- ☐ O.K. to fax to this number _________

☐ Work Telephone ____________________

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Other _________________________

____

___________________________________ Patient Signature

___________________________________ Date

___________________________________ Printed Name

___________________________________ Date

The Privacy Rule generally requires healthcare providers to take reasonable to limit the use or disclosures and requests for *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply to use or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of *PHI* disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note*: Uses and disclosures for TPO may be permitted without prior consent in an emergency*

Record of Disclosures of Protected Health Information

Date	Disclosed to Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

Pro-Active Physical Therapy

Notice of Privacy Practices
Acknowledgement

I hereby acknowledge that Pro-Active Physical Therapy has furnished a copy of their Notice of Privacy Practices to me directly. I understand that it is my responsibility to read this notice and that my medical information may be disclosed for treatment, billing and other necessary purposes outlined in the notice.

____________________________ ______________________________
Patient Representative

_________________ _________________
Date Date