New Patient Information

Date: ____________________

Contact Information

First Name: ______________________________ Last Name:_________________ Middle Initial:_____

What do you prefer to be called?____

LOCAL ADDRESS

Street: ____ Apt.: ______

City:______________________ State:________________________________ Zip Code: ______

SECONDARY ADDRESS

Street: ____ Apt.: ______

City:______________________ State:________________________________ Zip Code: ______

PHONE NUMBER & EMAIL

Home Phone: ______________________________ Work Phone: ____________________________

Cell Phone: __________________________ Email Address: ________________________________

How do you preferred to be contacted? ____

EMERGENCY CONTACT

Contact Name: ____________________________ Contact Phone: __________________________

What is your relationship to the Contact?____

Personal Information

DATE OF BIRTH: Month: _____________ Day:______________ Year:____________ Age: ______

SOCIAL SECURITY NUMBER: ____

Community Information

HOW DID YOU HEAR ABOUT US? *Check all that apply.*

- ○ Doctor Referred (see above)
- ○ Internet Search
- ○ My Insurance Company
- ○ External Signage
- ○ As A Fitness Clinic Member
- ○ Attorney Referred (please name): ______________________________________
- ○ At A Community Event (which one?): __________________________________
- ○ Referred By Someone I Know (please name): ____________________________
- ○ Other (please list): ____

5975 North Federal Highway, Suite 244
Fort Lauderdale, FL 33308

info@clearchoicept.com
Phone (954) 610-2253 Fax (954) 772-1742

New Patient Information

Physician Information

WERE YOU REFERRED BY A PHYSICIAN? ○ Yes ○ No

Referring Physician (if selected "Yes" above)

Name: ______________________ Specialty: ______________

Street: ______________________ Suite: ______

City: ______________ State: ______________ Zip Code: ______

Phone Number: ______________ Fax Number: ______________

Primary Care Physician (if different than referring physician)

Name: ______________________ Last Seen: ______________

Street: ______________________ Suite: ______

City: ______________ State: ______________ Zip Code: ______

Phone Number: ______________ Fax Number: ______________

Insurance Information

PRIMARY INSURANCE COMPANY: ______________________

Policy Number: ______________________

Insured's Name: ______________________

Street: ______________________

City: ______________ State: ______________ Zip Code: ______

Phone Number: ______________ Fax Number: ______________

SECONDARY INSURANCE COMPANY: ______________________

Policy Number: ______________________

Insured's Name: ______________________

Street: ______________________

City: ______________ State: ______________ Zip Code: ______

Phone Number: ______________ Fax Number: ______________

Background Information

HAVE YOU HAD HOME HEALTH CARE? ○ Yes ○ No Last Seen: ______________

Agency Name: ______________________

HAVE YOU BEEN IN A CAR ACCIDENT WITHIN IN THE LAST YEAR? ○ Yes ○ No

Date of Accident: ______________ **DO YOU HAVE AN ATTORNEY?** ○ Yes ○ No

Physical Therapy Initial Evaluation Form

Patient #: ____________________________

Provider: ____________________________

Date: ___________________

Patient Information

First Name: ______________________ Last Name:______________ Occupation:___________

Birthdate: ______________________ Age: __________ Height: ________ Weight: _________lbs

Home/Cell Phone: _____________________________________ Employer: _________________________

Currently Employed? ○ Yes ○ No ○ Modified

Rehab Information

1. Chief complaint/ailment/injury: ____

2. Date of injury: ______________________________ Date of surgery: ______________________

3. Briefly describe how you were injured:

____

____

4. Have you received therapy for this condition? ○ Yes ○ No When: _______________

How many visits? ________________

5. Has your condition been getting: ○ Worse ○ Same ○ Better

6. Are your symptoms: ○ Constant OR ○ Intermittent

7. Circle the number that best correspons to your pain:

AT BEST: 0 1 2 3 4 5 6 7 8 9 10 (EXCRUCIATING PAIN)

AT WORST: 0 1 2 3 4 5 6 7 8 9 10 (EXCRUCIATING PAIN)

8. What decreases/makes your condition better? *(Mark all that apply.)*

○ Bending	○ Movement	○ Rest	○ Better in AM
○ Sitting	○ Standing	○ Heat	○ Better as day progresses
○ Rising	○ Walking	○ Ice	○ Better in PM
○ Changing Positions	○ Lying	○ Medication	○ N/A Cast Just Removed

9. What increases/makes your condition worse? *(Mark all that apply.)*

○ Bending	○ Movement	○ Rest	○ Better in AM
○ Sitting	○ Standing	○ Heat	○ Better as day progresses
○ Rising	○ Walking	○ Ice	○ Better in PM
○ Changing Positions	○ Lying	○ Medication	○ N/A Cast Just Removed

10. Previous medical intervention? *(Mark all that apply.)*

○ X-RAY MRI ○ CATSCAN ○ INJECTIONS ○ OTHER: ____________________

Physical Therapy Initial Evaluation Form

Patient #: ______________________________

Provider: ______________________________

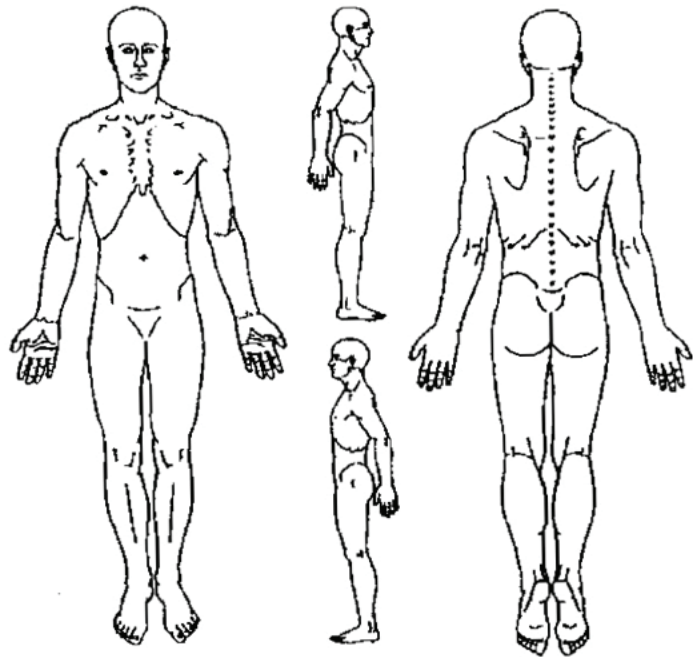
11. What are your goals to be achieved by the end of therapy?

____

____

Draw in areas of pain on body diagrams using appropriate symbols. *(If you are completing this form on the computer, print form after completion and mark the diagram with a pen.)*

Severe Pain	**********
Moderate Pain	00000000
Dull Ache	∩∩∩∩∩∩
Radiating Pain	↑↓↑↓↑↓↑↓
Numbness/Tingling	XXXXXX



Medical Information

MARK ALL THAT APPLY: ***THIS INFORMATION IS CONFIDENTIAL AND REMAINS PART OF YOUR CHART.*

- ○ Difficulty Swallowing
- ○ Fever/Chills/Sweats
- ○ Unexplained Weight Loss
- ○ Pacemaker
- ○ History of Smoking
- ○ Depression/Anxiety
- ○ Cancer
- ○ Motion Sickness
- ○ Osteoporosis
- ○ Heart Trouble
- ○ Shortness of Breath
- ○ History of Alcohol Abuse
- ○ Myofascial Pain
- ○ Stroke
- ○ High Blood Pressure
- ○ Blood Clots
- ○ HIV/Hepatitis
- ○ History of Drug Abuse
- ○ Fibromyalgia
- ○ Arthritis
- ○ Anemia
- ○ Bleeding Problems
- ○ Epilepsy/Seizures
- ○ Diabetes
- ○ Pregnancy

Previous Surgeries:______________________________

Other: ______________________________

Medications: ______________________________

____

Allergies: ______________________________

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Health Insurance Portability and Accountability Act:
Compliance Privacy and Confidentiality Policy

ClearChoice PHYSICAL THERAPY

THIS NOTICE COVERING THE PRIVACY OF YOUR PROTECTED HEALTH INFORMATION IS REQUIRED BY LAW. THIS HEALTHCARE FACILITY IS REQUIRED TO ABIDE BY THE TERMS OF THIS NOTICE WHICH IS CURRENTLY IN EFFECT. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

How We Will Use or Disclose Your Health Information:

I. **Treatment:** We will use your health information for treatment. Information will be recorded by health care professional, to determine the course of treatment. Members of the health care team will record actions and observations. Physicians will know how you are responding to treatment. We will provide your physician or subsequent health providers with copies of reports to assist with your treatment after discharge.

II. **Payment:** We will use your health information for payment. Reimbursement is due at the time of services rendered. The information on or accompanying the bill may include information that identifies you as well as the health care provided.

III. **Health Care Operations:** We will use your health information for regular health operations. Quality Improvement Teams may use information in your health record to assess the care and outcome in your case and others like it. This will then be used in an effort to continually improve the quality and effectiveness of the health care and services we provide.

IV. **Business Associates:** There are some services provided in our facility through contracts with Business Associates. Business Associates may be accountants, consultants, billing services, transcription services, and attorneys. When these services are contracted, we may disclose your health information to our Business Associates so that they can perform their job. We require the Business Associate to appropriately safeguard your health information.

V. **Communication with Family:** The health care professionals may disclose to a family member, other relative close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

VI. **Food and Drug Administration:** The health care facility may disclose to the FDA health information to adverse events with respect to product and product defects, or post marketing surveillance information to enable product recalls, repairs or replacement.

VII. **Public Health:** As required by law, the health care facility may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

VIII. **Law Enforcement:** The health care facility may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

IX. **Report:** When a work force member or business associate believes in good faith that the health care facility has engaged in unlawful conduct or otherwise violated professional or clinical standards and may potentially be endangering one or more patients, workers or the public health authority or attorney.

Any other use or disclosure other than stated above will be made only with your written authorization and that authorization may be revoked by you in writing. We may contact you to provide appointment information and we may provide information related to treatment alternative or other health related benefits and services that may be of interest to you.

Health Insurance Portability and Accountability Act:
Compliance Privacy and Confidentiality Policy

Although your health record is the physical property of the health care facility, the information in your records belong to you. **You have the following rights:**

A. You may request that the health care facility NOT use or disclose your health information for a particular related treatment, payment, the facility's general health care operations, and/or to a particular family member, other relative or close friend. Although we will consider your request, please be aware we are in no obligation to accept it or to abide by it. For more information about this right, see code 45 of Federal Regulations (C.F.R.) 164.522 (a). The facility may contact you to provide appointment reminders. You have the right to receive confidential communications of your protected health information. As a caveat, please understand that communications between staff and patients during therapeutic exercises may be compromised given the physical plant.

B. If you are dissatisfied with the manner which or the location where you are receiving communications from us that are related to your health information, you may request that we provide you with such information by alternative means or at alternative locations. Such a request must be made in writing and submitted to the health care facility's Privacy Officer. We will attempt to accommodate all reasonable requests. For more information about this right, see 24 C.F.R. 164.522 (b).

C. You may request to inspect and/or obtain copies of health information about you, which will be provided to you in the periods established by law. If you request copies, the health care facility will charge you a reasonable and cost-based fee. For more information, see 45 C.F.R. 164.524. Upon written or verbal request of a patient, a release of records form is to be provided to the patient for his or her signature; this form should be provided to the patient as expeditiously as possible; after receipt of the executed records release, a copy of the requested patient records is to be provided to the patient in the manner designated by the patient; such record copies are to be provided within 14 day of receipt of the executed release and in no case, later that 30 days after receipt of the release.

D. If you believe that any health information in your record is incorrect or if you believe that important information is missing, you may request that we correct the existing information or add the missing information. Such requests must be made in writing and must provide a reason to support the amendment. For more information, see 45 C.F.R. 164.526.

E. You may request that we provide you with a written accounting of all disclosures made by us during the time for which you request. Such request must be made in writing. Accounting will not apply to the following: disclosures made for reasons of treatments, payment or health care operations, disclosures made to you or your legal representative or any other individual involved in your care: disclosures to correctional institutions or law enforcement officials: and disclosures for national security purposes. You will not be charged for your fist account request; any requests thereafter will be charged at a reasonable fee. For more information, see164.524. No other disclosures or uses of your medical records will be made other than stated in this document without your written authorization, see 164.520 sub (b) sub (ii) (E).

F. You may request that we provide you with a written accounting of all disclosures made by us during the time for which you request. Such request must be made in writing. Accounting will not apply to the following: disclosures made for reasons of treatments, payment or health care operations, disclosures made

to you or your legal representative or any other individual involved in your care: disclosures to correctional institutions or law enforcement officials: and disclosures for national security purposes. You will not be charged for your fist account request; any requests thereafter will be charged at a reasonable fee. For more information, see164.524. No other disclosures or uses of your medical records will be made other than stated in this document without your written authorization, see 164.520 sub (b) sub (ii) (E).

G. You have a right to obtain a paper copy of this document.

H. You may revoke an authorization to use or disclose health information, except to the extent that action has already been taken. Such a request must be made in writing.

If you have any questions and would like additional information, you may contact the health care facility's Privacy Officer.

If you believe that your privacy rights have been violated, you may file a complaint with the health care facility. These complaints must be filed in writing on a form provided by the health care facility. The form can be obtained from the Privacy Officer and returned to the Privacy Officer. You may also file a complaint with the secretary of the Federal Department of Health and Human Services. There will be no retaliation for filing a complaint. There will be no changes in this privacy practice without a written notice provided to you setting forth any change.

HIPAA Compliance
Officer: Erik Bleeker, MSPT
Clear Choice Physical Therapy
(954) 610-2253

______________________________	______________________________	__________
Signature of Patient	Print Name	Date
______________________________	______________________________	__________
Signature of Parent or Guardian	Print Name	Date

Authorization & Consent

ClearChoice PHYSICAL THERAPY

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

Clear Choice Physical Therapy is hereby authorized to disclose all or any part of the medical record of the patient named in the registration as per patient request. The authorization is effective for three years from the date of service and may be revoked with written notification.

AUTHORIZATION TO OBTAIN MEDICAL RECORD INFORMATION

I hereby authorize Clear Choice Physical Therapy, to obtain my Protected Health Information including, but not limited to, history and physical exam, lab reports, progress notes, X-ray reports, substance abuse (including alcohol/drug abuse), mental health (including psychotherapy notes), HIV related information (including AIDS related testing). I understand that this authorization will expire 365 days from the date I have signed this form and that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified, except to the extent action has already been taken in reliance upon it. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.

CONSENT FOR MEDICAL TREATMENT

The undersigned hereby consents to any therapy, treatment, or facility services rendered to the patient under the general and special instructions of the therapist assigned to care for me. I also acknowledge that no guarantee or warranty has been made by said therapist of Clear Choice Physical Therapy as to the results of any treatment given or performed.

USUAL AND CUSTOMARY RATES

I hereby authorize my insurance benefits to be paid directly to Clear Choice Physical Therapy. I understand that I am financially responsible for all amounts not covered by insurance, including deductible, co-payments, and continued treatment and services when insurance benefits are exhausted or if benefits are denied at any point during rehabilitation. I authorize Clear Choice Physical Therapy to release any information necessary to process my medical claim. I understand that charges for all services provided to me by Clear Choice Physical Therapy which are not covered by insurance are my personal responsibility. My signature below constitutes my agreement to pay for such services. I acknowledge that I am responsible for payment for all services that my insurance does not cover and that it is my responsibility (and not Clear Choice Physical Therapy's responsibility) to know and understand the extent of my health insurance coverage.

Payment is required at the time of service for co-payments and deductibles. Should there be a remaining balance after your insurance company has paid their portion; uncovered amounts shall be paid within 30 days of the date of the billing statement. After 30 days, a late fee of $20 per month will be assessed. After 60 days, your account may be transferred to a collection agency. The fee for a returned check is $25 in addition to the amount of the check. This charge covers our bank fees as well as additional processing and billing costs.

As a service to you. We will bill your insurance carrier. We will make two (2) attempts to bill and re-bill for the correct payment. Should our efforts be unsuccessful, you will be responsible to pay for the services. We will provide you with the forms and codes needed for you to try to obtain reimbursement from your insurance carrier. In the event it is necessary to assign the account to a collection agency or if legal action is necessary to enforce the terms of this agreement, I agree to be responsible for all fees and costs incurred by Clear Choice Physical Therapy, including attorney's fees.

My signature below constitutes agreement to adhere to the financial responsibilities outlined in this agreement.
MEDICAL EMERGENCIES - It is our policy to call 911 in case of medical emergencies.

I certify that I have read and understand fully the above information.

Signature of Patient or Responsible Party	Print Name	Date
Signature of Parent or Guardian	Print Name	Date

Graston Technique
Informed Consent

ClearChoice PHYSICAL THERAPY

Graston Technique® (GT) is an advanced, evidence-based form of instrument-assisted soft tissue mobilization that enables physical therapists to effectively and efficiently address soft tissue lesions and fascial restrictions resulting in improved patient outcomes.

GT uses specially-designed stainless steel instruments with unique treatment edges and angles to deliver an effective means of manual therapy. The use of the GT instruments, when combined with appropriate therapeutic exercise, leads to the restoration of pain-free movement and function.

The Graston Technique® protocol has several basic components:

1. Warm up of the treatment area.
2. Graston Technique® Treatment.
3. High repetition, low load exercise.
4. One to three 30-second stretches.
5. Low repetition, high weight exercise.
6. Ice therapy.
7. Stretching/rehabilitation exercise.

As we work to build your plan of care, and determine the extent to which GT could benefit you, we ask that you answer the following questions:

1.	Do you bruise easily?	Yes	No
2.	Do you bleed for a long period of time after you cut yourself?	Yes	No
3.	Are you taking blood thinners or anticoagulants?	Yes	No
4.	Do you take aspirin on a regular basis?	Yes	No
5.	Do you take cortisone on a regular basis?	Yes	No
6.	Have you ever had inflamed veins or blood clots?	Yes	No
7.	Do you have surgical implants in your body?	Yes	No
8.	Do you have diabetes or kidney disease?	Yes	No
9.	Do you currently have any infections?	Yes	No
10.	Do you have uncontrolled high blood pressure?	Yes	No

Should you have any questions about GT, we encourage you to ask your physical therapist during your visit.

All components of Graston Technique® have been explained to me. I understand the risks of the procedure and I give my full consent for treatment.

____________________ Sign Name

____________________ Print Name

__________ Date

Cancellation & No-Show Policy
For Insured and Self-Pay Patient

1. **Cancellation Policy** – At Clear Choice Physical Therapy, we recognize that changes in personal schedules occur. In such cases, we ask that you contact us at least 24 hours prior to your scheduled appointment, allowing us to accommodate other patients that may be looking for available appointment times. Monday appointments and appointments following a holiday must be cancelled by 3:00 pm on Friday or the last business day preceding the holiday. Late cancellations will result in a twenty-five-dollar ($25) fee to be paid prior to receiving services at the following scheduled appointment.
2. **"No Show" Policy** – Not showing up for an appointment creates a significant problem for our practice. At Clear Choice Physical Therapy, we care about our patients and do our best to accommodate their needs and schedules; we appreciate and expect the same treatment from our patients. In the event of being a "no show" for a scheduled appointment, a **fifty-dollar ($50)** fee will be charged to your account, payable prior to receiving services at the following scheduled appointment.

We appreciate your cooperation and understanding.

Signature of Patient	Print Name	Date
Signature of Parent or Guardian	Print Name	Date

Note (Source: MLN Matters Number MM5613, updated Nov. 12, 2014): According to Chapter 1, section 30.3.13 of the Medicare Claims Processing Manual, which is attached to CR5613, Centers for Medicare and Medicaid Services policy allows physicians, providers, and suppliers to charge Medicare beneficiaries for missed appointments, provided that they do not discriminate against Medicare beneficiaries but also charge non- Medicare patients for missed appointments and the charges for Medicare and non-Medicare patient are the same.