FLORIDA WEST COAST PHYSICAL THERAPY & REHABILITATION CENTER INC.

PATIENT REGISTRATION - HISTORY

This form will become part of your permanent medical record. This information is required in order to assist the therapist in providing optimum care for this and future medical problems. The therapist must have this information and it is required to be part of your medical record by all insurance companies, including Medicare.

PLEASE FILL OUT AS COMPLETELY AS POSSIBLE

Date: _____ Referring Physician: _____

Full Name: _____ Age: _____ Date of Birth: _____

Sex: F M Marital Status: S M D W Social Security #: _____

Local Addr: _____ City/State: _____ ZipCode: _____

Primary Addr: _____ City/State _____ ZipCode: _____

Home #. _____ Email: _____

Cell #: _____

Retired: Y N Spouse's Name: _____

Employer: _____ Spouse's Employer/Phone: _____

Address: _____

_____ Emergency Contact: _____

Work #: _____ Phone #: _____

Heart/Lung Problems: Y N Weight: Height: Chief Complaint:

Do You Smoke? Y N How Much:

History of Alcohol / Substance Abuse? Y N Accident: Y N Date: Auto? Y N Work? Y N

Allergies: Surgery: Y N Date: Type:

Current Medications: Any Previous Physical Therapy in Current Calendar Year? Y N

Past Medical History: (List Surgeries / Illnesses)

My General Health is: (SEE PAGES 2 & 3)

Excellent Good Fair Poor

INSURANCE INFORMATION

Primary Ins: ID#: Group#:

Policy Holder: DOB: Relation:

Secondary Ins: ID#: Group#:

Policy Holder: DOB: Relation:

WORKERS COMP / MVA

Date of Injury: Notice of Injury Completed by Employer? Y N Are you presently working? Y N

PERSONAL MEDICAL HISTORY: Do you have now or have you had (past) any of the following conditions?

Condition	*Now*	*Past*	*Comments*
Alcohol / Drug abuse			
Allergy (Hay Fever)			
Anemia			
Anxiety			
Arthritis (Rheumatoid)			
Arthritis (Osteoarthritis)			
Asthma			
Bladder / Kidney Problems			
Blood Clot (leg)			
Blood Clot (lung)			
Blood Transfusion			
Breast Lump (benign)			
Cancer Breast			
Cancer Colon			
Cancer Other Type			
Cancer Ovarian			
Cancer Prostate			
Cataracts			
Chicken Pox			
Colon Polyp			
Coronary Artery Disease			
Depression			
Diabetes (adult onset)			
Diabetes (childhood onset)			
Diverticulosis			
Emphysema (COPD)			
Fractures (broken bones)			Where?
Gallbladder Disease			
Gastroesophageal Reflux (Heartburn/GERD)			
Glaucoma			
Gout			
Gynecological Conditions (Endometriosis)			
Gynecological Conditions (Fibroids)			
Gynecological Conditions (Other)			
Heart Attack			
Hepatitis – Type A			
Hepatitis – Type B			
Hepatitis – Type C			
Hepatitis – Other			
High Blood Pressure			
High Cholesterol			
Hip Fracture			
Irritable Bowel Syndrome			
Kidney Disease / Failure			
Kidney Stones			
Liver Disease			
Migraine Headaches			
Osteoporosis			
Pneumonia			
Prostate (enlargement)			
Prostate (nodules)			
Seizure / Epilepsy			
Skin Condition (Eczema)			

please go to next page

Personal History continued

Condition	*Now*	*Past*	*Comments*
Skin Condition (Psoriasis)			
Skin Condition (Abnormal Moles)			
Sleep Apnea			
Stomach Ulcer			
Stroke			
Thyroid (Nodule)			
Thyroid High (Overactive) / Hyperthyroidism			
Thyroid Low (Underactive) / Hypothyroidism			
Other (list)			
Other (list)			

□ **Check box if you have no history of significant medical illnesses.**

SURGICAL & PROCEDURE HISTORY – Please check off any procedure or surgeries. List any abnormal finding, details or complications under comments.

Surgical Procedure	*Code*	*Yes*	*Year*	*Comments*
Abdominal surgery	HX0004			
Angiogram (heart)	HX0541			
Angiogram (vascular)	HX0503			
Appendectomy (appendix removal)	HX0023			
Back surgery (lumbar)	HX0032			
Biopsy (location in comments)	HX0524			
Breast Biopsy	HX0043			Circle: Right Left Both
Breast surgery	HX0056			Circle: Right Left Both
Cataract surgery	HX0196			
Colonoscopy	HX0095			
Coronary Bypass	HX0526			
Coronary Stent	HX0243			
C-Section				
Echocardiogram (heart)				
EGD (Stomach Endoscopy)	HX0491			
Gallbladder Removal	HX0349			Circle: Laparoscopic (HX0271)
Heart Surgery (other than coronary bypass checked above)				
Hip Surgery	HX0224			Circle: Right Left Both
Hysterectomy (partial, ovaries left)				Circle: Laparoscopic Vaginal Abdominal
Hysterectomy (total, including ovaries)	HX0600			Circle: Laparoscopic Vaginal Abdominal
Knee Surgery	HX0261			Circle: Right Left Both
LEEP (Cervix surgery)	HX0105			
Neck (Spine) surgery	HX0554			
Ovary Removal	HX0355			Circle: Right Left Both
Pulmonary Function Test	INT0015			
Sigmoidoscopy	HX0426			
Sinus Surgery	HX0427			
Stress Test (stress echo)	HX0433			
Stress Test (thallium/perfusion)	HX0294			
Stress Test (treadmill)	HX0191			
Tonsillectomy	HX00535			
Tubal ligation	HX00536			
Vasectomy	HX0356			
Other (list)				

□ **Check box if you have never had any medical procedures or surgeries.**

please go to next page

PRE-EXAM FORM: In order to evaluate your condition fully, please be as accurate as possible. Thank you.

PATIENT NAME:_____ AGE:_____ GENDER: ❑ Female ❑ Male

OCCUPATION:_____ ARE YOU WORKING NOW? ❑ Yes ❑ No

1.	Where is your pain/problem?		
2.	What caused your pain/problem?		
3.	Approximately when did it start?		
4.	List ONE ACTIVITY you are unable to do, that you absolutely want to be able to do again:		
5.	Have you ever had this same (or similar) pain/problem before?	❑ Yes (If yes, when and describe?) ❑ No	
6.	In your understanding, what do you think will make it better?		
7.	How optimistic are you that you'll get better? (circle one)	Not at all.....Mildly optimistic.....Fairly.....Very optimistic.....Extremely	
8.	What are some potential obstacles to you getting better?		
9.	Over the next 30-days, how many hours per week will you commit to getting better?		
10.	What are you expecting from therapy?		
11.	On the scale, circle your worst pain level in the past couple of days:	*Mild* *Moderate* *Severe* 0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10	

Total:

I understand that my candidacy for a rehabilitation program will be dependent upon my ability and willingness to improve. I have answered the questions above honestly and accurately to the best of my ability.

Patient Signature (or guardian):_____ Date: _____

PATIENT REGISTRATION - HISTORY

RELEASE OF INFORMATION AND CONSENT FOR TREATMENT

The above information is privileged and confidential. I agree that this information and information from my medical records may be released to other consulting physicians, therapists, or medical-related agencies involved in my care at the therapist's discretion. I hereby consent for Florida West Coast Physical Therapy & Rehabilitation Center, Inc. to commence and carry out therapy treatment for my condition as indicated.

Patient's Signature _____ **Date** _____
Witness: _____

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INSURANCE RELEASE

I, _____, hereby grant permission to Florida West Coast Physical Therapy & Rehabilitation Center, Inc. to release any pertinent information to my insurance company upon request to facilitate the payment of reimbursement of any covered therapy charges.

I UNDERSTAND THAT INDIVIDUAL OR GROUP COVERAGE POLICIES MAY NOT PAY ALL OF THE CHARGES SUBMITTED, AND I, THEREFORE, AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT PAID BY MY INSURANCE. I ALSO UNDERSTAND THAT I WILL BE PERSONALLY RESPONSIBLE FOR ALL ADDITIONAL COSTS OF COLLECTION, INCLUDING ATTORNEY'S FEES AND COURT COSTS, SHOULD MY ACCOUNT BECOME PAST DUE.

Patient's Signature _____ **Date** _____
Witness: _____

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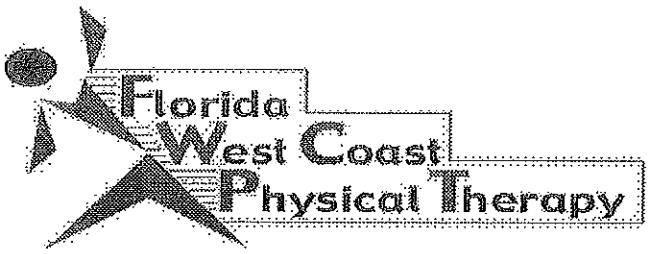
INSURANCE ASSIGNMENT

I hereby authorize payment of my applicable insurance benefits directly to Florida West Coast Physical Therapy & Rehabilitation Center, Inc. for the treatment rendered.

Patient's Signature _____ **Date** _____
Witness: _____



Venice
256 S. Nokomis Ave., Ste. 2
Venice, FL 34285
PHONE: (941) 484-1939
FAX: (941) 484-7804

PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have been provided with Florida West Coast Physical Therapy's Notice of Information Practices. I understand that Florida West Coast Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand that Florida West Coast Physical Therapy will consider the requests for restriction on a case by case basis, but does not have to agree to requests for restriction.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Florida West Coast Physical Therapy's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____
Patient Name

_____
Signature

_____
Date

Florida West Coast Physical Therapy

Professional, Personalized, "Hands On" Care

256 S. Nokomis Ave., #2, Venice, FL 34285
(941) 484-1939 • Fax (941) 484-7804

PRIVACY NOTICE

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.**

YOUR RIGHTS

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

YOUR CHOICES

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

OUR USES AND DISCLOSURES

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us at: Florida West Coast Physical Therapy, Greg B. Miller, Administrator, 256 S. Nokomis Avenue # 2, Venice, Florida 34285. Phone (941) 484-1939
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information (FWCPT never sells personal information)
- Most sharing of psychotherapy notes (FWCPT has no psychotherapy information)

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.

Example: A therapist treating you for an injury asks your doctor about your overall health condition.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

- We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
- www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do Research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

- We can share health information with a corner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date of this notice: September 1, 2013.

For further information please contact:

Greg B. Miller, P.T.
Administrator
Florida West Coast Physical Therapy
256 S. Nokomis Avenue, #2
Venice, Florida 34285
Phone: (941) 484-1939
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www.floridawestcoastpt.com