Preferred Physical Therapy
Associates, Inc.

3994 W Hillsboro Blvd, Deerfield Beach FL 33433 Tel: 954-360-7779 Fax: 561-395-6995

Welcome to Preferred Physical Therapy Associates, Inc.

Our comprehensive rehabilitation facility offers the advantage of

Physical, Occupational and Speech Therapy under one roof. Our multi therapist facility offers you the opportunity to benefit from varied approaches and techniques. **Our Total Therapy Solution** ensures that you are evaluated or screened by each discipline. This allows us to make sure that nothing is missed in your care.

You may be treated by more than one of our experienced therapists during the course of your treatment in order to accommodate your schedule.

Please try to arrive on time for your appointment and allow plenty of time for quality therapy and rest periods.

Always check in at the front and have a seat in our waiting area until your therapist comes for you and make sure you have enough appointments for at least the next 3 weeks.

Family MUST wait in the reception area due to HIPPA.

ALL CO-INSURANCE OR CO-PAYMENTS ARE DUE AT CHECK IN.

AT LEAST 24 HOURS NOTICE IS REQUIRED TO CANCEL AN APPOINTMENT.

We appreciate this opportunity to provide your therapy. We know that you will be very pleased with our therapists and state of the art facility. If you have been satisfied with your therapy **please tell your friends and your Doctors.** Your suggestions and comments are always welcome.

Thank you.

Preferred Physical Therapy Associates, Inc.

Welcome to our clinic.

Please take a few minutes to answer the following questions so we may better assist you.

Name: _____ _____ _____
First MI Last

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

Date of Birth: _____/_____/_____ **Social Security #:** _____/_____/_____

Email _____@_____

Preferred method of contact for appointment reminders: ____ Email ___Text Message ___ Phone Call

Telephone: _____ **Cell Phone:** _____

In case of emergency, who should we contact? _____

Telephone: _____ **Relationship:** _____

Who may we thank for this referral: _____

Primary Insurance: _____ **Policy Number:** _____

Policy Holder: _____

Secondary Insurance: _____ **Policy Number:** _____

Policy Holder: _____

Are you involved in litigation? ___YES ___NO If yes, please provide information: _____

_____

_____

_____

Preferred Physical Therapy Associates, Inc.

Patient's Name: _____ **DOB: ___/___/___**

Please list all current medications:

Medication	Reasons for Medication

Preferred Physical Therapy Associates, Inc.

Patient's Name: _____ **DOB:** ___/___/___

CHIEF COMPLAINTS:

Please list part(s) of your body that you are experiencing difficulties with? _____

_____

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

CONDITION	YES	NO	CONDITION	YES	NO
Asthma, Bronchitis, Emphysema			Severe or Frequent Headaches		
Shortness of Breath			Vision or Hearing Problems		
Coronary/Heart Disease			Numbness or Tingling		
Do you have a Pacemaker			Dizziness or Fainting		
High Blood Pressure			Balance problems		
Heart attack or Chest pain			Radiation of symptoms into the arms/legs		
Recent Hospitalization			Weakness		
Parkinson's Disease			Weight/Energy Loss		
Stroke/TIA			Hernia		
Blood Clot/ Emboli			Varicose Veins		
Epilepsy/Seizures			Allergies		
Thyroid trouble/Goiter			Any pins or Metal implants		
Anemia			Joint Replacements		
Infectious Disease			Neck Injury/Surgery		
Diabetes			Shoulder Injury/Surgery		
Kidney Problems			Elbow Injury/Surgery		
Cancer or Chemotherapy/Radiation			Back Injury/Surgery		
Arthritis/Swollen Joints			Knee Injury/Surgery		
Osteoporosis			Leg/Ankle/Foot Injury/Surgery		
Gout			Do You Smoke?		
Sleeping Problems/Difficulties			Are you Pregnant?		
Emotional/Psychological Problems			Are you sensitive to Heat/Ice?		
Bowel or Bladder Problems			Other		

Other concerns/complains: _____

_____

Preferred Physical Therapy Associates, Inc.

CONSENT FOR TREATMENT

AUTHORIZATION OF PAYMENT

I, hereby authorize the therapy treatment by Preferred Physical Therapy Associates, Inc. for myself, my spouse or any minor child. I, hereby authorize Preferred Physical Therapy Associates, Inc. to provide medical care, treatment and all diagnostic examinations and any procedures required in the Plan of Care during the visits and appointments. I indemnify Preferred Physical Therapy Associates, Inc. from any injuries that may arise during the course of treatment, including Theragun and use of treadmill

I hereby authorize Preferred Physical Therapy Associates, Inc., their agents or any representative or billing company to request or receive any medical information needed in the care or treatment or billing of same needed. I further authorize the parties to release any medical or billing information required to any party needed. I hereby release all the above parties from any liabilities, responsibilities, damages or claims that might arise from the release of any information.

I understand that all therapy services will be billed directly to Medicare or other primary insurance company and any secondary insurance provider by a third party billing company. I certify that the information given by me in applying for payment is correct. I authorize the release of all records on request and that payments of authorized benefits are made on my behalf. I hereby direct all payments be made directly to Preferred Physical Therapy Associates, Inc.

MEDICARE PATIENT'S ONLY:

Medicare requires that we certify that the reason you are receiving therapy is unrelated to any open or prior auto/ liability accident/case. By signing below, you are acknowledging that the treatment you are seeking at our facility, Preferred Physical Therapy, is unrelated to any injuries sustained in an open or prior auto or liability case and you are NOT currently receiving Home Health Services. If this is the case, please notify the front office.

Medicare has imposed therapy services caps for physical & speech therapy combined and occupational therapy. We want to assure you, that if services are provided in excess of the therapy cap; we have deemed these treatments are medically necessary and YOU ARE NOT RESPONSIBLE FOR ANY PAYMENTS SHOULD MEDICARE DECIDE NOT TO REIMBURSE US.

I understand that this billing procedure is done as a courtesy and in the event that the payment is received by me, I will immediately forward same or in the event that either insurance providers fail to pay the claims, I will be responsible for immediate payment in full. I understand that I will be responsible for any deductibles, coinsurance charges not covered by my carriers.

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

Print Name: _____

Preferred Physical Therapy Associates, Inc.

NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you get access to this information. Please review carefully.

We care about our patients' privacy and strive to protect the confidentiality of your medical information in our practice. New Federal legislation and all additional final rules require that we issue this official notice of our privacy practices. HIPAA is short for the **Health Insurance Portability Act of 1996**. This law regulates patient privacy, information access, fraud prevention, group health plan requirements, and billing simplification throughout the health care industry. HIPAA protects the privacy of your individual health information. **It also gives you additional rights to access change or restrict the use of your health information. It also gives you additional rights to access change or restrict the use of your health information. It allows you full access to your records whether written or electronic.**

We use or disclose your health information to carry out treatment, co-ordinate and provide your care with your physician, health care professionals outside this office or your family that are all involved in your care. **Your records cannot be used for marketing purposes. We will only contact you or your family by telephone for the sole purpose of confirming your appointments**. We use or disclose your health information to obtain payment for your treatment as required by your insurance company or Medicare. **If either your insurance company or Medicare is not paying for any treatments, your records will not be shared with them.** We use or disclose your health information to improve the quality of our services, plan better ways of treatment or evaluating our staff performance. **The only other permitted disclosure of your health information would be to the Secretary of Health and Human Services to investigate or determine compliance, any Federal, state or local law requirements or a Workers' Compensation Claim.**

We will only disclose any of your information, amend your information, amend to whom we share your information or provide you with a copy if requested by you in writing to the **Office Administrator**. You may file any complaint in writing to the Secretary of Health and Human Services, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201.

I HAVE INDICATED ALL MEDICAL AND OTHER INFORMATION TO BETTER ASSIST PREFERRED PHYSICAL THERAPY ASSOCIATES, INC. IN MY CARE AND TREATMENT AND TO PREVENT ANY HARM TO ME DURING MY THERAPY. I HAVE READ ALL THE ABOVE AND MAY REQUEST A COPY AT ANY TIME.

Please list who we may discuss your information with:

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

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

Print Name: _____

Preferred Physical Therapy Associates, Inc.

****Transportation Waiver of Liability, Assumption of Risk**** **** & Indemnity Agreement****

Waiver: In **consideration** of being offered a free car service (transportation) to assist me getting to and from therapy, I, for myself, my heirs, personal representative or assigns, **do hereby release, waive, discharge, and covenant not to sue Preferred Physical Therapy Associates, Inc., its officers, directors, employees, contractors or agents,** resulting in personal injury, accidents, or illnesses (including death) and property loss arising from, but not limited to, participate in the free transportation. I understand and agree that it is my responsibility to assess the hazards and risks inherent in this free transportation program.

Assumption of Risk: Participation in the free transportation carries with it certain inherent risks that cannot be eliminated regardless of the care taken to avoid injuries. I hereby elect to voluntarily participate in said free transportation with full knowledge of the risks of my own free choice. I further understand that the insurance policies carried by PREFERRED PHYSICAL THERAPY ASSOCIATES, INC. do not cover any circumstances arising from the free transportation. **I have read this agreement and I know, understand, and appreciate these and other risks that are inherent in the transporting of me. I hereby assert that my participation is voluntary and that I knowingly assume all risks.**

Indemnification and Hold Harmless: I also agree to INDEMNIFY AND HOLD PREFERRED PHYSICAL THERAPY ASSOCIATES, INC. HARMLESS from any and all claims, actions, suits, procedures, cost, expenses, damages and liability, including attorney's fees brought as a result of my involvement in the free transportation and to reimburse them for any such expenses incurred.

Severability: The undersigned further expressly agrees that the foregoing waiver and assumption of risks agreement is intended to be as broad and inclusive as is permitted by the laws of the State of Florida and that if any portion thereof is invalid, it is agreed that the balance shall, not withstanding, continue in full legal force and effect.

Acknowledgement of Understanding: I have read this waiver of liability, assumption of risk, and indemnify agreement, fully understand its terms, and **understand that I am giving up substantial rights, including my right to sue.** I acknowledge that I am signing the agreement freely and voluntarily, and **intend by my signature to be a complete and unconditional release of all liability** to the greatest extent allowed by law.

Signature _____ Date: _____

Print Name: _____

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CANCELLATION POLICY

Preferred Physical Therapy strives to provide excellent care for all of its patients. We have several therapists on staff who have expertise in different areas of the body. This enables our facility to treat a large range of medical issues. We have been providing therapy in South Florida for over 11 years and have helped thousands of patients. Each and every person who is treated at our office becomes our number one priority and our patients appreciate the dedication of the entire staff.

In order for Preferred Physical Therapy to continue its ability to provide patients with excellent treatment, it is also imperative that you understand that you must be present for your appointments. If you do not come to your visits, then your problem is not going to improve. In addition, our therapist are scheduled according to the time that has been reserved for each client. If a patient does not show for their assigned appointment or cancels a couple hours prior to their scheduled visit, then the therapists time is wasted, and a patient who would have come in for that appointment loses the opportunity for receiving care. Preferred Physical Therapy wants to ensure that time is available for the people who want care and need therapy, and who come to their visits**. Unless it is a valid emergency, patients who are no shows, cancel the day of their appointment and/or give less than 24 hours notice, will incur a fee of $50**. This policy helps to ensure that all patients can continue to receive the care they deserve in a timely manner.

I have read the policy letter.

Signature: _____ Date:_____

Print: _____

Preferred Physical Therapy Associates, Inc.

PHOTO/INFORMATION RELEASE FORM

I hereby grant permission to Preferred Physical Therapy Associates, Inc to use photographs and/or video of me and name taken at *3994 W Hillsboro Blvd, Deerfield Beach FL 33442* in publications, news releases, online, and in other communications related to marketing, reviews and advertising

_____

(Signature of patient, or Guardian of Children under age 18)

Name _____

Address _____

_____

Phone (day)_____(evening)_____

Email Address (optional) _____

Thank you!