

Welcome to Preferred Physical Therapy Associates, Inc.

We are proud to provide comprehensive rehabilitation services with Physical, Occupational, and Speech Therapy all under one roof.

Our highly experienced therapists use a variety of approaches and techniques to ensure you receive the most effective care. Each patient is evaluated by the appropriate discipline to design a personalized treatment plan tailored to your needs.

Important Information for Your Visit:

- Please arrive on time for your scheduled appointment.
- Check in at the front desk and take care of your co-pay and membership before therapy begins.
- After check-in, please have a seat in the waiting area until your therapist comes for you.
- Due to HIPAA regulations, family members must remain in the reception area.
- Make sure you have enough scheduled appointments to cover at least the next 4 weeks.
- A minimum of 24-hour notice is required for cancellations to avoid a late fee.
- Our therapists work as a team. You may be treated by more than one therapist during your plan of care to best accommodate your schedule.

We value the trust you place in us and look forward to supporting your rehabilitation journey. Our goal is to provide exceptional care in a state-of-the-art facility where patients are always treated like family.

If you are satisfied with your therapy experience, please share your feedback with us, your friends, and your doctor. Your suggestions and comments are always welcome.

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

Name: (First MI Last): _____

Date of Birth: ____/____/____ Social Security #: ____/____/____

Marital Status: Single Married Widowed Divorced

I am a returning patient, and my address has not changed.

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email _____

Preferred method for appointment reminders: Email Text Message Call

Emergency Contact Name: _____

Telephone: _____ Relationship: _____

Who may we thank for this referral: _____

Are you involved in litigation? Yes No

If yes, please provide information: _____

Patient's Name: _____ Date: _____

Patient's Signature: _____ Date: _____

CONSENT FOR TREATMENT

I authorize Preferred Physical Therapy Associates, Inc. to provide therapy treatment, medical care, diagnostic examinations, and any procedures required in my Plan of Care for myself, my spouse, or my minor child. I release Preferred Physical Therapy Associates, Inc. from liability for any injuries that may occur during the course of treatment, including the use of equipment such as the Theragun or treadmill.

I authorize Preferred Physical Therapy Associates, Inc., its representatives, or billing agents to request, receive, or release any medical or billing information necessary for my care or for insurance purposes. I release all parties from liability related to the exchange of this information.

I understand that all therapy services will be billed directly to Medicare, my primary insurance, and any secondary insurance by a third-party billing company. I certify that the information I provide for billing is accurate and agree to notify the front desk immediately of any insurance changes. I authorize all benefit payments to be made directly to Preferred Physical Therapy Associates, Inc. I understand I am responsible for any deductibles, co-insurance, or charges not covered by my insurance. If payments are sent directly to me, I agree to forward them immediately.

Patient's Name: _____ Date: _____

Patient's Signature: _____ Date: _____

MEDICARE PATIENTS ONLY:

By signing below, I certify that my treatment at Preferred Physical Therapy Associates is not related to any open or prior auto or liability case, and that I am not currently receiving Home Health Services.

Medicare places limits on therapy services; however, when therapy is deemed medically necessary, Preferred Physical Therapy Associates will continue to provide care. Patients will not be held responsible for therapy costs solely due to Medicare's therapy limits.

Patient's Name: _____ Date: _____

Patient's Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

This notice explains how your medical information may be used and disclosed, and how you can access it. Please read carefully.

We value your privacy and follow federal law (HIPAA – Health Insurance Portability and Accountability Act of 1996) to protect your health information. HIPAA gives you rights to access, request changes, or place limits on how your health information is used. You also have the right to obtain a copy of your records, whether written or electronic.

How We Use Your Information

- **Treatment:** To coordinate your care with physicians, healthcare providers, or family members involved in your treatment.
- **Payment:** To obtain payment from your insurance company or Medicare. If they are not paying for your treatment, your records will not be shared.
- **Healthcare Operations:** To improve our services, plan treatments, or evaluate staff performance.
- **Other Disclosures:** As required by law, including compliance investigations, Workers' Compensation claims, or federal, state, and local legal requirements.

We do not use your health information for marketing. You may only be contacted by phone for appointment reminders.

Your Rights

- Request copies or amendments of your records (in writing to the Office Administrator).
- Request limits on how your information is shared.
- File a complaint with the U.S. Department of Health and Human Services if you believe your privacy rights have been violated.

By signing below, you acknowledge this notice and authorize Preferred Physical Therapy Associates, Inc. to use the information you have provided for safe and effective care. You may request a copy of this notice at any time.

Please list the individuals with whom we may discuss your information:

Name	Relationship	Contact Number

Patient's Signature: _____ Date: _____

CANCELLATION POLICY

At Preferred Physical Therapy, our priority is delivering excellent care to every patient. With a team of experienced therapists, we are able to treat a wide range of medical conditions and have proudly served the South Florida community for over 11 years. Every patient we treat is important to us, and we are committed to providing the time, expertise, and dedication needed for your recovery.

To make this possible, it is essential that patients attend their scheduled appointments. Consistent attendance ensures progress in treatment and allows us to provide care to as many patients as possible. When appointments are missed without notice, valuable therapy time is lost, and other patients who may have needed care miss the opportunity to be seen.

Policy

- We require at least 24 hours' notice for cancellations.
- Cancellations made with less than 24 hours' notice, same-day cancellations (without emergency reasons), or missed appointments ("no-shows") will result in a **\$50 cancellation fee.**
- Exceptions will be made for valid emergencies.

This policy helps us respect our therapists' time and ensures that all patients who need therapy can receive it in a timely manner.

By signing below, you acknowledge that you have read and understand this policy.

Patient's Name: _____ Date: _____

Patient's Signature: _____ Date: _____

PATIENT HISTORY

Age _____ Weight: _____ Lbs Height: _____ Ft. _____ Inches.

Briefly describe the problem that brought you in today, how it began, and when.

Do you have or have ever had any of the following? (Check yes or no)

CONDITION	YES	NO	CONDITION	YES	NO
Asthma, Bronchitis, Emphysema			Severe/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/ Embolism			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			Are you allergic to Latex?		

Other: _____

Are you receiving any assistance at home in the form of Home Health Care with daily tasks (Home Health Care includes Physical, Occupational and Speech Therapies, Wound Care, Nursing, Aides or Help with Medications)? Yes No

Patient's Signature: _____ Date: _____

