Palm City Physical Therapy

PATIENT SUMMARY

To better serve you, it is important that you complete this medical history as completely and as accurately as possible

PART IA PERSONAL INFORMATION

Name_____ Summer Address_____

Mailing Address._____ _____

_____ _____

Age_____Date of Birth_____Phone Number_____ Cell Phone_____

Email _____

Date of Initial Injury _____ Referring Physician_____

Date of Most Recent Increase of Symptoms_____Primary Care Physician_____

Please check the appropriate response.

	YES	NO
Do you smoke?		
Do you exercise regularly?		
Is your current condition work accident related?		
Is your current condition auto accident related?		
Have you had physical, occupational, speech, massage or chiropractic care for any reason this year?		

PARTI PAST MEDICAL HISTORY

Please check YES if you have ever {in your life) had, or do you presently have any of the following

		YES
1	Anemia / Blood Disease	
2	Bone / Joint Problem	
3	Arthritis / Rheumatism	
4	Allergies	
5	Back Trouble	
6	Breathing Problems (any kind)	
7	Broken Bones / Dislocation *I* Sprains	
8	Cancer or Tumor	

		YES
9	Diabetes	
10	Dizziness *I* Fainting	
11	Epilepsy/ Seizure Disorder	
12	Fibromyalgia Syndrome	
13	Headaches	
14	Head / Spinal Injury	
15	Heart Disease / Chest Pain	
16	Hernia / Rupture	

		YES
17	High Blood Pressure or Hiqh Cholesterol	
18	Lung Disease	
19	Paralysis	
20	Pregnancy (Current)	
21	Skin Disease or Sores That Won't Heal	
22	Stroke	
23	Swelling of Feet or Joints	
24	Other	

Please give details of all above YES answers below (listing the corresponding number)

Number	Illness Details

Do you have a pacemaker or metal implant(s)? Yes__ No__

Have you had X-rays, CT scans, or MRI?_____Results._____

Please continue to next page

PART II PAST SURGERIES

If YOU have had any prior surgeries please give details below

Surgery / Procedure	Date

PART III MEDICATIONS

Are you allergic to any medications? YES / NO If YES, what? _

I you are currently taking any medications please list below

Medication	
1	
2	
3	
4	

Medication	
5	
6	
7	
8	

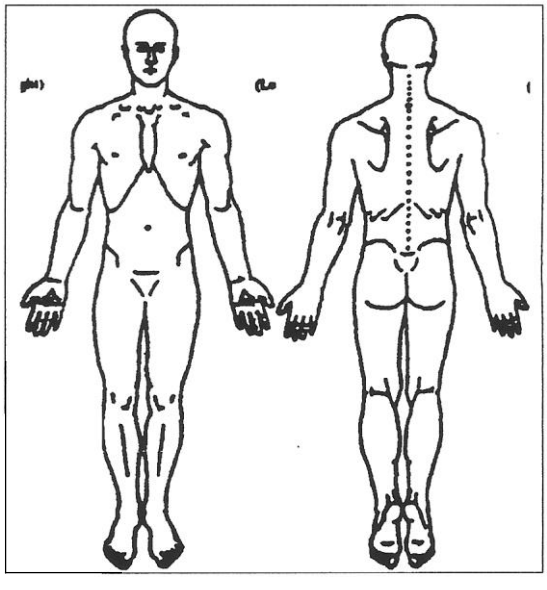
Part IV Pain Level Evaluation

How long have you had pain?_____
Did the pain begin gradually?_____
What caused the pain to start?_____
Is the pain worse at night?_____
What makes your pain worse?_____
What makes your pain better?_____
How does activity affect the pain?_____
How does rest affect the pain?_____
Do you have special sensations?___ Pins/Needles___ Burning___ Tingling___ Numbness

Do you have trouble sleeping?_____
How do you feel upon rising in the morning?_____
What goals do you want to accomplish with therapy?

Please circle your pain level during the last week.
Please indicate with an X the location of any pain, numbness or tingling you have experienced during the last week

No Pain O 1 2 3 4 5 6 7 8 9 10 **Severe Pain**



"I certify that I have reviewed and understand the above information supplied by me, and that it is true and correct to the best of my knowledge"

Patient Signature _____ Date _____

PALM CITY PHYSICAL THERAPY, INC

Kay Deerman PT
3539 SW Corporate Parkway
Palm City, FL 34990

Release of Patient Records Authorization

I hereby authorize Palm City Physical Therapy, Inc. to release copies of my patient records which include written information such as progress notes, evaluations, medical history, physical examinations, reports, and billing information incurred on my behalf, or any pertinent information related to and concerning my physical condition, care and treatment.
To/from:

My Doctor Yes or No

Insurance Companies Yes or No

My Attorney Yes or No

My Physical Therapist Yes or No

Other: _____Yes or No

Other: _____ Yes or No

Specific description of Information to be disclosed:

_____

_____

_____

This authorization is provided pursuant to Florida Statutes section 465.057 and regulations pursuant to the Health Insurance Portability and Accountability.

Signature_____
Patient
Name_____
Print

PALM CITY PHYSICAL THERAPY, INC.
Kay Deerman PT
3539 SW Corporate Parkway
Palm City, FL 34990
PH-772-220-3444/ Fax-772-220-3839

INSURANCE ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependents) have insurance coverage with _____ and assign directly to Palm City Physical Therapy all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether ornot paid by insurance. I hereby authorize Palm City Physical Therapy to release information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submission.

_____

Responsible Party Signature

_____

Relationship

CONSENT TO DISCLOSE PATIENT INFORMATION / HIPAA

"I understand this center's Notice of Privacy Practices and give permission for my protected health information to be disclosed for purposes of communicating results, findings, care decisions and appointments to the family members or friends listed below:"

Name _____

Name _____

Name _____

Name _____

Patient Name (please print) _____

Patient / Guardian Signature _____ Date _____

PALM CITY PHYSICAL THERAPY, INC
Kay Deerman PT
3539 SW Corporate Parkway
Palm City, FL 34990
PH-772-220-3444/ FAX 772-220-3839

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received and /or reviewed the Notice of Privacy Practices for Palm City Physical Therapy, Inc. I further acknowledge that I have been encouraged to read the entire notice as it provides information about how my protected health information may be used and disclosed.

The Notice of Privacy Practices is subject to change.

I understand that this acknowledgement form will be placed in my patient chart and shall remain there for 6 years.

Name of
Patient_____
_____
Print

Signature of Patient or Legal
Representative_____

Date: _____

If not signed by patient, please indicate relationship:

_____ Parent or guardian of a minor
_____Guardian

_____ Other Representative

Please note: Refusing to sign this document will not impact your ability to receive physical therapy

Signed_____Date_____
_____

Palm City Physical Therapy
No-Show & Cancellation Policy
HIPAA Compliant

Patient Name: _____

Date of Birth: _____

Phone Number: _____

No-Show & Cancellation Policy
To ensure we can provide timely care to all our patients, we have established the following policy:

1. **1st No-Show (Without 24-Hour Notice):**
   No fee will be charged, but a **courtesy reminder** will be given.
2. **2nd No-Show (Without 24-Hour Notice):**
   A **$50 fee** will be charged. This fee must be paid before scheduling future appointments.
3. **More than 5 No-Shows or cancellations:**
   If you miss 5 or more appointments without 24-hour notice, you will be **discharged** from the facility and will no longer be scheduled for care.

Cancellation Policy:

- Cancellations and Rescheduling must be made at least **24 to 48 hours in advance**.
- You may reschedule or cancel by phone at **772-220-3444** or email at **palmcityphysicaltherapy@gmail.com**.

HIPAA Compliance Notice:
All patient information, including appointment history and payment records, is confidential and handled in compliance with HIPAA regulations. No medical or billing information will be shared without your consent, except as required for processing payments or as permitted under HIPAA.

By signing below, I acknowledge and agree to the No-Show & Cancellation Policy and confirm that I have been informed of my rights regarding the privacy of my information under HIPAA.

Patient Signature: _____
Date: _____