

Beachside Physical Therapy

Welcome to Beachside Physical Therapy! *We would like to thank you for making the decision to include us in your rehabilitative journey. The following is some information many of our patients ask about during their first visit. We hope that you find answers to some of your questions here but if not you are always free to give us a call.*

Physical Therapy: What to Expect

After an examination on your first visit your Physical Therapist (PT) will create goals for you to meet throughout your care as well as determine the methods that will be used to meet these goals. Your PT will use physical treatments, manual therapy, therapeutic exercises and other techniques specially catered to your needs in order to help you meet your goals. Your PT may even assign “homework”- exercises for you to perform on your own at home. It is very important that you follow the PT’s instructions as compliance is the number one factor determining your rehabilitative success. During your time at Beachside your PT may add to, delete from, or alter your care plan to ensure your success in your treatment. Always heed the changes and continue to follow your PT’s instructions. Remember: they want you to get better!

During your treatment at Beachside Physical Therapy you will work with one or two additional PTs other than the PT that performed your initial examination. **THIS IS OK.** All of the Physical Therapists at Beachside Physical Therapy are licensed and knowledgeable about your problems. Having more than one PT is beneficial to your care as each may have different methods of curing the same ailment. There are also scheduling benefits of having more than one PT: if one is busy during the time you need to schedule you can always book with the other. Beachside utilizes the teamwork approach to provide you with a higher quality treatment plan. If you find that you work well with a particular therapist you are more than welcome to request that therapist for your appointments. We ask, however, that when you do this you be more flexible with your appointment scheduling as your requested appointment times with this particular therapist may already be booked.

After your first treatment your body may be sore. **THIS IS NORMAL.** Your Physical Therapy plan may include exercises that work muscles previously not used before and this may cause slight discomfort. This does not mean you should stop Physical Therapy. Inform your PT about any discomforts you may be having before, during, or after your treatment. They may make recommendations on how to solve these issues including altering your care plan, using ice or heat, or decreasing the exercise load.

Insurance: What will they pay? What do I pay? How does it work?

All insurance plans are different. Some plans may cover your Physical Therapy at 100% and others may require a co-payment from you. On your first visit we will obtain a copy of your insurance card. Our billing department will then call your insurance company to determine what your coverage is. By your third visit* you will receive an *Explanation of Benefits* from our billing department explaining what your insurance company has told us. It will tell you what your insurance company will pay, what you will have to pay, and any limitations your plan may have with regards to Physical Therapy. This is a **complimentary** service we provide to our patients. You are more than welcome to call your insurance company on your own to inquire about your benefits.

Some insurances have confusing limitations, caps, and restrictions that may be difficult to understand. For these questions you may want to call your insurance company directly or you may call our Account Representative, Laura Williams, at 321-773-8155.

For those patients who require it, Beachside Physical Therapy offers payment plans as well as interest free financing. We do this as a service to our patients so that finances do not deter you from obtaining the care that you need. For more information about these plans, please contact Laura Williams at 321-773-8155.

GENERAL QUESTIONS? Call: 321-777-4033

BILLING QUESTIONS? Call Laura Williams, Accounts Representative: 321-773-8155

* Some insurances plans may take longer to obtain benefits.

Patient ID#: _____ **Beachside Physical Therapy New Patient Demographic Sheet** Clinic#: _____

Last Name: _____ First Name: _____ MI. _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: ____/____/____ Social Security #: ____-____-____ Circle One: MALE FEMALE

Email Address: _____ Spouse Name: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Family Physician: _____ Phone: _____

How did you hear about Beachside Physical Therapy? Circle One:

Referred by a Physician I am a previous patient Friend Postcard Saw the sign Phonebook A Church Bulletin

Other: _____

Financial Information (If the patient is a minor, please complete this information)

Name of Responsible Party: _____ Relationship: _____

Home Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Insurance Information (The following section must be filled out COMPLETELY.) I hereby instruct the insurance company below to make payment to Beachside Physical Therapy.

Primary Insurance: _____ Member ID#: _____

Policy Holder Name: _____ Relationship: _____ DOB: ____/____/____

Secondary Insurance: _____ Member ID#: _____

Policy Holder Name: _____ Relationship: _____ DOB: ____/____/____

I understand and agree that I am ultimately responsible for the balance of my account for any professional services rendered, regardless of my insurance. I have read all the information above and certify this information is true and correct to the best of my knowledge. I will notify Beachside Physical Therapy of any changes in my status or the above information. I hereby authorize any treatment(s) agreed upon with the Physical Therapist and my referring physician which are deemed medically necessary.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I also authorize Beachside Physical Therapy, Inc. and its staff to call my home and leave messages regarding appointments with my spouse and/or on the answering machine. Furthermore, I authorize the use of facsimile transmission, e-mail transmission, internet transmission, and electronic transmission of my personal health information for the purpose of treatment, payment, and healthcare operations.

Patient or Responsible Party Signature: _____ Date: ____/____/____

Patient ID#: _____

DETERMINATION OF PRIMARY PAYOR:

• Have you received **OUT PATIENT PHYSICAL THERAPY SERVICES** this calendar year? YES NO

If so, where? _____

• Is Medicare your secondary? If so, please indicate the type by circling below. YES NO

Working Age Beneficiary End Stage Renal Disease No Fault Insurance Black Lung

PHC or Other Federal Veteran’s Administration Disabled Beneficiary Other: _____

• Are you currently receiving, or plan on receiving, any type of home health care including nursing and home health aid? YES NO

• Are you currently receiving or plan on receiving any type of chiropractic care? YES NO

• Is this injury due to an automobile accident? YES NO

If “YES”, what was the date of the accident? _____

• Is this injury work related? YES NO

If “YES”, what was the date of injury? _____

• Is your injury the result of any other type of accident? YES NO

If “YES”, please provide us with the details: _____

I understand that if payment of services by Medicare or other insurance payers is denied due to false information I will be held responsible for these charges.

Patient or Responsible Party Signature: _____ Date: ____/____/____

Patient HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use of disclosure that occurred prior to the date I revoke this consent is not affected.

I give permission to share appointment, billing or medical information with the person(s) named here:

Patient or Responsible Party Signature: _____ Date: ____/____/____

Beachside Physical Therapy

2030 South Patrick Drive, Ste 3; Indian Harbour Beach, FL 32937
Indian Harbour Beach • Indialantic • Melbourne • Viera • Palm Bay

Dear Patient:

During the course of your treatment it is extremely important that you are compliant with all of your scheduled appointments to enhance your recovery and follow the treatment plan prescribed by your physician.

Cancelled appointments severely impact your treatment plan as well they prevent Beachside Physical Therapy from scheduling acutely ill patients who could have been seen that day, but were not because someone else was scheduled for that time spot. No shows also drive up the cost of patient care for everyone as staffing and overhead cost for services go unused.

Due to an increasing problem with patients missing scheduled appointments or “No Shows”; I regrettably must institute a “No Show Policy”. A fee of \$75.00 will be charged to your account for failure to show up for a scheduled appointment, or for cancellations with less than 24 hours notice. This charge is not covered by insurance. We understand emergencies occur therefore rescheduling appointments is possible so please inform the front desk.

It is also important that you arrive on time for scheduled appointments to ensure the quality of your care as well as the quality of care for patients who do arrive on time for their appointments.

Patient care is of the utmost importance to the staff of Beachside Physical Therapy as evidenced by our past successes. We look forward to serving your needs and please let us know if there is anything we can do to help!

Sincerely,

Steve Ryland

Owner/Physical Therapist

Patient or responsible party signature _____

Printed Name _____

Beachside Physical Therapy

PATIENT MEDICAL HISTORY

Name (PRINTED) _____ Referring Physician _____

Family Physician _____ Date of first doctor visit for this injury _____

Last date worked due to this injury _____ Date returned to work after this injury _____

Is an attorney involved in this case? YES NO

Have you had surgery for this injury? YES NO Number of surgeries: 1 2 3 4

Type of surgery _____ Date _____

Please enter your – HEIGHT _____ WEIGHT _____ AGE _____

Are you currently taking any prescriptions or non-prescription medications? YES NO

List any medications currently being taken:

Have you had any of the following medical or rehabilitative services for this injury/episode?

	YES	NO		YES	NO
Chiropractor	___	___	EMG/NCV	___	___
Neurologist	___	___	Myelogram	___	___
Orthopedist	___	___	Emergency Room Care	___	___
General Practitioner	___	___	CT Scan	___	___
Occupational Therapy	___	___	MRI	___	___
Physical Therapy	___	___	X-Rays	___	___

OTHER _____

Do you now have or have you ever had ANY of the following?

	YES	NO		YES	NO
Asthma, bronchitis, or emphysema	___	___	Severe/frequent headaches	___	___
Shortness of breath/chest pain	___	___	Vision/hearing difficulties	___	___
Coronary heart disease or angina	___	___	Dizziness or Fainting	___	___
Heart attack or surgery	___	___	Weight loss/Energy Loss	___	___
Do you have a pacemaker	___	___	Hernia	___	___
High blood pressure	___	___	Allergies	___	___
Stroke/TIA	___	___	Any joint/metal implants	___	___
Blood clot/emboli	___	___	Joint Replacement	___	___
Epilepsy/seizures	___	___	Shoulder injury/surgery	___	___
Anemia	___	___	Elbow/hand injury/surgery	___	___
Infectious disease	___	___	Neck/back injury/surgery	___	___
Diabetes	___	___	Knee injury/surgery	___	___
Cancer or chemotherapy/radiation	___	___	Leg/ankle injury/surgery	___	___
Arthritis/swollen joints	___	___	Are you pregnant	___	___
Osteoporosis	___	___	Do you smoke	___	___
Sleeping problems/difficulties	___	___	Difficulty/Frequent urinating	___	___
Anxiety	___	___	Depression	___	___
Alzheimer's	___	___	Dementia	___	___
Thyroid Condition	___	___	Night Pain	___	___

List any other information that would assist us in your care

Are you aware of your diagnosis? _____ YES NO

Would you like to speak with a social worker/vocational counselor about the aspects of your rehabilitation program? YES NO

Do you play golf? YES NO Do you play tennis? YES NO Are you a runner? YES NO

Patient or responsible party signature _____ Date: _____

I have reviewed this information with the patient.

Therapist (PRINTED) _____ Therapist (SIGNATURE) _____ Date: _____