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 patient 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 second 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, give you an estimate of what you will have to pay, and any limitations your plan may have with regards to Physical Therapy. This is a **courtesy** service we provide to our patients. You are more than welcome to call your insurance company on your own to inquire about your benefits.

It is important that you know that physical therapy bills differently than a regular doctor visit. Instead of seeing one charge on your Insurance carriers EOB, it is possible to see upwards of 4 different charges. This is because we must bill for each procedure that is performed at each visit. And because you will be progressing at each visit, it is likely that we will be doing different procedures at each appointment, giving you a different charge for each visit.

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 our Patient Representative 777-4033
Billing Questions? Call our Account Representatives 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: ______________________
**** Would you like us to text message you with your next appointment time?** Yes ____ No ____

Home Address: ____

City: ____ State: _____________ Zip: ____________________

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

Email Address: ___________________________________ Spouse Name: _________________________________
***** Would you like us to email you with your next appointment time?** Yes ______ No ______
***** May we share your email address with Beachside Health Studio?** Yes ______ No ______

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:

Name: ______________________________ Relationship: ______________________________

Patient or Responsible Party Signature: ______________________________ Date: ____/____/_______

Print Name: ______________________________ Signer's Relationship to Patient: ______________________

Beachside Physical Therapy

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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 ____

Patient Name: ____ Patient ID #: ____________

MEDICAL HISTORY

Condition	Yes	No
Allergies	O Yes	O No
Anemia	O Yes	O No
Anxiety	O Yes	O No
Arthritis	O Yes	O No
Asthma	O Yes	O No
Cancer	O Yes	O No
Cardiac Conditions	O Yes	O No
Cardiac Pacemaker	O Yes	O No
Chemical Dependency	O Yes	O No
Circulation Problems	O Yes	O No
Currently Pregnant	O Yes	O No
Depression	O Yes	O No
Diabetes	O Yes	O No
Dizzy Spells	O Yes	O No
Emphysema/Bronchitis	O Yes	O No
Fractures	O Yes	O No
Gallbladder Problems	O Yes	O No
Hepatitis	O Yes	O No
High Blood Pressure	O Yes	O No
Incontinence	O Yes	O No
Kidney Problems	O Yes	O No
Metal Implants	O Yes	O No
Multiple Sclerosis	O Yes	O No
Osteoporosis	O Yes	O No
Parkinson's	O Yes	O No
Rheumatoid Arthritis	O Yes	O No
Seizures	O Yes	O No
Strokes	O Yes	O No
Thyroid Disease	O Yes	O No
Tuberculosis	O Yes	O No
Vision Problems	O Yes	O No

Describe any other conditions or precautions:

Fall History

Injury as a result of a fall in the past year? O Yes O No Date of Fall:__________________________

Two or more falls in the last year? O Yes O No Dates of Falls:________________________

**** **Surgical History**

Body Region: _______________ Surgery Type: ___________________ Date of Surgery: _____/_____ Month / Year

Body Region: _______________ Surgery Type: ___________________ Date of Surgery: _____/_____ Month / Year

Body Region: _______________ Surgery Type: ___________________ Date of Surgery: _____/_____ Month / Year

Body Region: _______________ Surgery Type: ___________________ Date of Surgery: _____/_____ Month / Year

**** **Current Medications**

Drug: ________________________ Dosage: _________ Reason for Taking:______________________________

Drug: ________________________ Dosage: _________ Reason for Taking:______________________________

Drug: ________________________ Dosage: _________ Reason for Taking:______________________________

Drug: ________________________ Dosage: _________ Reason for Taking:______________________________

Drug: ________________________ Dosage: _________ Reason for Taking:______________________________

Patient or responsible party signature____ Date:_____________

Therapist (print) _________________________ *Therapist (signature)* ___________________________