HEALTH INFORMATION RELEASE FORM

In order to assist you in receiving your health information from Peoples Physical Therapy, please complete this form.

I authorize the person(s) listed below to have access to any and all of my health information, billing and health insurance information. Peoples Physical Therapy is permitted to share any medical information with them, including test results and information disclosed during office visits.

Persons authorized to receive my medical information (full name and phone number):

_____
_____
_____
_____

You may notify me or the parties listed above with appointment reminders and other information regarding my health information as follows:

_____ Message on answering machine (Phone number) _____

_____ Message on work voicemail (Phone number) _____

_____ Message on cell phone (Phone number) _____

I understand and direct that this authorization will remain in effect until it is revoked by me in writing.

Do you want to be reminded of appointments by:

_____ Text Cell Service Provider:_____

_____ Email _____

_____ Telephone

_____
Patient – Print Name

_____
Patient – Signature

_____
Date

Notice of Information Practices is available to read upon request

New Patient Orientation Sheet

****Please read carefully to avoid any misunderstandings in the future****

1. Reserve your appointment well in advance to ensure availability. Appointment slots fill up quickly.
2. Be on time for your appointment. If you are going to be more than **15 minutes** late from the scheduled time, you may be required to reschedule for another day.
3. We require a 24-hour notice when cancelling your appointment. If you **fail to show** for your appointment or cancel with less than a 24 hour notification, you will **personally be charged $25.00 a visit.**
4. Know your insurance plan benefits. We will do our best to answer as many questions as possible, but it is ultimately your responsibility to know your insurance plan benefits. Co-pays, number of visits allowed, authorizations, etc.
5. Co-pays and Co-insurance are due at the time of service.
6. It is unlawful to waive co-payments, deductibles, co-insurance or other patient responsibility payments.
7. Payment methods available for your convenience include: personal checks, credit cards, cash, or monthly payment plan.

I have read and fully understand the policies described above. I hereby agree to follow these policies to the best of my ability.

New patient signature_____

These policies help promote a smooth running facility and enable us to provide you with the highest possible quality of care. We thank you for your cooperation and your support!

No Show / Cancellation Policy

We realize that emergencies and other scheduling conflicts arise and are sometimes unavoidable; however, if you are unable to keep your scheduled visit, advanced notification allows us to fulfill other patient's scheduling needs and keeps our clinic operating at an efficient level. Due to our one on one treatments, missed appointments are a significant inconvenience to your physical therapist, the clinic and other patients.

1. Please provide the office with 24-hour notice to change or cancel an appointment. Patients who do not attend their scheduled appointment or do not provide 24-hour notice to change a scheduled appointment will be responsible for a $25.00 office visit charge. This charge cannot be billed to insurance and must be paid on or before the next scheduled appointment.
2. We reserve your scheduled appointment just for you. We schedule our patients so that we may provide optimum treatment outcomes. 24-hour notice allows us to place another patient in your cancelled appointment time to receive needed treatment.
3. Accident claims adjusters and insurance companies expect regular attendance to physical therapy as a requirement of an approved treatment plan. If appointments are missed or cancelled on a regular basis, it could affect the status of your claim. Your treatment plan has been established by your physical therapist to get you back to your regular activities as quickly as possible. Missing your scheduled appointments hinders that process and prolongs recovery.
4. After missing two appointments without notice or same-day cancellation, you will be placed on same-day scheduling, which would not allow you to schedule any appointments in advance. Missing three appointments, without notice or same-day cancellation, you will be removed from our patient list.

   Of course, we realize that emergencies happen. In the unfortunate circumstance when that does occur, please let us know immediately.

   Thank you for providing our office staff, physical therapists and other patients with this courtesy.

_____ _____

Patient Signature Date

_____ _____

Signature of Responsible Party Date

Top Tier Sports Medicine

Patient Information Date:_____

Last Name: _____ First Name: _____ MI. _____

Address:_____ SSN: _____

City: _____ State: _____ Zip Code: _____

Telephone#:(____)_____ Mobile Phone #:(____)_____ Work Phone#: (____)_____

Sex: Male / Female Date of Birth:____/____ /____ Email Address: _____

Marital Status

M S D W

□ □ □ □

Employment Status

□ Employed Full-time □ Employed part-time □ Unemployed

□ Student Full-time □ Student Part-time □ Retired

Emergency Contact: _____Relationship: _____ Phone: _____

Family Physician: _____ Phone Number: _____

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

Name of Responsible Party: _____ Relationship: _____

Home Address: _____

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

How did you hear about us?

□ Referred by my physician □ Past Patient □ Friend, if so who may we thank? _____

□ Destination Brevard □ Running Zone □ Google □ Saw the Sign

Insurance Information:

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 Top Tier Sports Medicine 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 Top Tier Sports Medicine 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: ____/____/_____

Determination of Primary Payer

Injury Date or Date pain began: _____ If Injury - Where did Injury Occur?

□ **No Accident** □Home □Work □Auto Accident- What State? _____

□Other_____

Have you been treated by another: (**Please CIRCLE all that apply**) physical therapist, chiropractor, or Home Healthcare agency since January 1st of this year? No _____ Yes_____If yes, then:

Have you been discharged from their facility? No_____ Yes _____ Date last seen _____

Please fill out the following information for each that applies:

Physical Therapy Office _____ Phone #:_____

Home Health Care Agency_____Date you were discharged?_____

Have you had X-rays/MRI? When?_____ Where?_____

Medical History

Allergies	Yes □	No □	Dizzy Spells	Yes □	No □	MRSA	Yes □	No □
Anemia	Yes □	No □	Emphysema/Bronchitis	Yes □	No □	Multiple Sclerosis	Yes □	No □
Anxiety	Yes □	No □	Fibromyalgia	Yes □	No □	Muscular Disease	Yes □	No □
Arthritis	Yes □	No □	Fractures	Yes □	No □	Osteoporosis	Yes □	No □
Asthma	Yes □	No □	Gallbladder Problems	Yes □	No □	Parkinson's	Yes □	No □
Autoimmune Disorder	Yes □	No □	Headaches	Yes □	No □	Rheumatoid Arthritis	Yes □	No □
Cancer	Yes □	No □	Hearing Impairment	Yes □	No □	Seizures	Yes □	No □
Cardiac Conditions	Yes □	No □	Hepatitis	Yes □	No □	Smoking	Yes □	No □
Cardiac Pacemaker	Yes □	No □	High Cholesterol	Yes □	No □	Speech Problems	Yes □	No □
Chemical Dependency	Yes □	No □	High/Low Blood Pressure	Yes □	No □	Strokes	Yes □	No □
Circulation Problems	Yes □	No □	HIV/AIDS	Yes □	No □	Thyroid Problems	Yes □	No □
Currently Pregnant	Yes □	No □	Incontinence	Yes □	No □	Tuberculosis	Yes □	No □
Depression	Yes □	No □	Kidney Problems	Yes □	No □	Vision Problems	Yes □	No □
Diabetes	Yes □	No □	Metal Implants	Yes □	No □	Height _____	Weight _____	

Surgical History

Body Region: _____ Surgery Type: _____ Date: _____

Body Region: _____ Surgery Type: _____ Date: _____

Body Region: _____ Surgery Type: _____ Date: _____

Current Medications □ I do not take any medications □ See attached list of medications

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

PATIENT SIGNATURE: _____ DATE: _____

THERAPIST SIGNATURE: _____