Island Physio LLC
Physical Therapy

Welcome

Thank you for choosing Island Physio LLC to be your physical therapy provider. We will provide excellent physical therapy care and will strive to improve your function and well-being. During your care, we will focus on increasing your joint mobility, strength, activity tolerance, and improve your quality of life. It is our goal to teach and educate you about your diagnosis and/or injury so you will be better equipped to minimize or eliminate your pain/symptoms. However, it will be very important for you to be compliant with your home exercise program to maximize your rehab outcomes.

If you have any questions, please do not hesitate to ask. We are here to assist you through this injured state and to guide you to achieve normal or close-to-normal function.

Patient Attendance Policy

In order to maximize your physical therapy outcomes, it is crucial to maintain a consistent treatment schedule. However, if you are unable to make your appointment, we kindly request that you notify our office at least 24 hours in advance of your scheduled appointment time. If someone is not available to take your call, please leave a message on our voicemail. We recommend that you make up that missed appointment within the same week in order to comply with the treatment plan approved by your physician.

Cost of Treatment Policy

The cost of your treatment may be covered in whole or in part by your insurance company. You are responsible for payment of any deductibles, co-payments or denied claims. Patients should pay their co-payments at the time of service. The co-pay amount depends on the type of insurance coverage. It is the patient's responsibility to know what is covered under their specific insurance policy. Please call your insurance company for your individual physical therapy benefits. Cash, check, or credit card may be used for payment. There is a $25.00 fee for returned checks.

I have read, understand and agree with the above policies.

Signature: _____ **Date:** _____

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Consent for Use and Disclosure of Health Information

Notice of Privacy Practices

Please review our Notice of Privacy Practices. It provides a detailed description of our treatment, obtaining payment, and healthcare operations of the practice. It outlines the use and limitations of the disclosure of your health information and your right as a patient.

Island Physio LLC reserves the right to change or modify the privacy practices as outlined in our Notice of Privacy Practices. You may obtain a copy of our Notice of Privacy Practices at any time by contacting our office.

I have reviewed this consent form and your Notice of Privacy Practices. I give my permission to Island Physio LLC to use and disclose my or my child's health information to carry out treatment, obtaining payment, and healthcare operations.

_____
Name of Patient (Print)

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative

_____
Relationship of Patient Representative to Patient

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Patient Information

Last Name: _____ First Name: _____ M.I. ____ Sex: M or F

Birth Date: _____ Phone: Home _____ Cell _____

Address: _____

City _____ State _____ Zip Code _____

E-mail address: _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Insurance Information

Primary Insurance Company: _____

Name of insured: (Last)_____ (First) _____ (M.I.) _____

Birth Date: _____ Relationship to insured: __ Self __ Spouse __ Child __ Other: _____

Secondary Insurance Company: _____

Name of insured: (Last)_____ (First) _____ (M.I.) _____

Birth Date: _____ Relationship to insured: __ Self __ Spouse __ Child __ Other: _____

I was referred to Island Physio LLC by (please check one box):

__ Doctor _____

__ Friend/Relative _____ Was he/she a former patient? ___ Yes ___ No

__ Other _____

Assignment of Benefits and Release of Information to Insurance Company

I hereby authorize Island Physio LLC or its representative to release to my insurance company or its representative my information including the diagnosis and the examination and treatment records rendered to me during the period of such medical care.

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to Island Physio LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by my insurance company. In the event of default, I (we) promise to pay legal interest on the indebtedness, together with collection costs (plus $20.00 processing fee) and reasonable attorney fees as may be required to affect collection of this note.

The above information is correct to the best of my knowledge. I agree to accept Physical Therapy treatment as prescribed by my physician and provided by Island Physio LLC.

Signature: _____ Date: _____

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Patient History

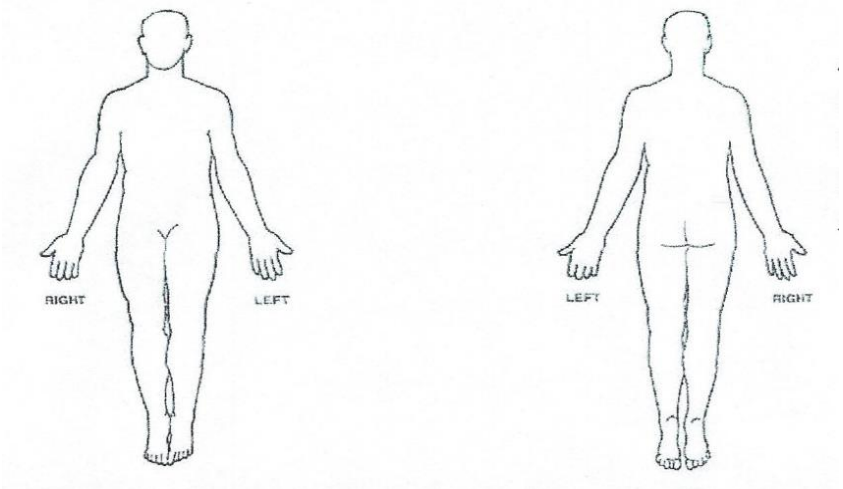
Name: _____ Age: _____

Next MD appt: _____

Please check "Yes or No" to the following conditions (if you have or ever had):

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Arthritis			Cancer/Tumor			Dizziness		
Osteoporosis			CVA/Stroke			Surgical Implants		
High Blood Pressure			Scoliosis			Pregnant		
Diabetes			Pacemaker			Seizures		
Heart Disease			Headaches					
Vascular Disease			Visual changes					
A significant weight change in the last few months?								
Does pain wake you up when you sleep?								

1. When did you first notice this condition (date)? _____
2. Since the onset of your symptoms, is it getting better, worse, or not progressing? _____
3. Where is the exact location of your symptoms? _____
4. Is this the first episode of your symptoms? (Please circle) **Yes** or **No**
   If no, when was your last episode and how long did it last for? _____
5. Have you had physical therapy this year? (Please circle) **Yes** or **No**
   If yes, for how many visits? _____
6. Have you been hospitalized for your symptoms/condition? (Please circle) **Yes** or **No**
   If yes, for how long? _____
7. Are you taking any medications? (Please circle) **Yes** or **No**
   If yes, please list. _____
8. How much of your daily activities are you able to perform on a scale from 0% to 100%? _____
9. On the body diagram, please indicate the location of your pain. Use the symbols below to indicate the type of pain.



Symbols:
^ = Dull Ache
/ = Stabbing
o = Numbness
- = Tingling
* = Burning

Pain Rating Scale (please circle your pain level at its worst and at its best)

0 1 2 3 4 5 6 7 8 9 10

No pain Mild pain Moderate pain Severe pain Emergency Room