Patients Name: ______________________________

Patients Height: ______________________________

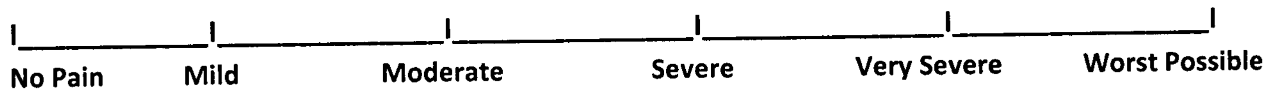
Patients Weight: ______________________________

BMI: ______________________________

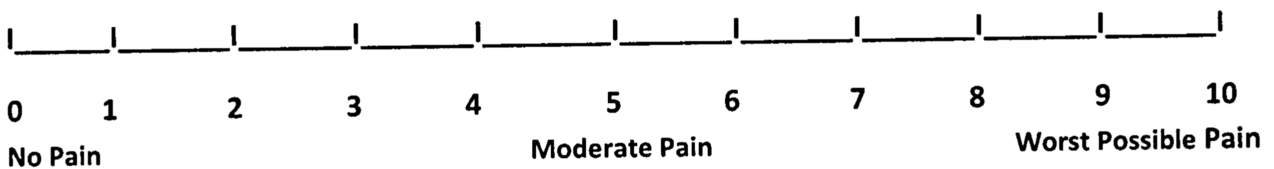
Medication List: **(Please list ALL of the medications you are currently taking)**

Medication Name	Dosage	Frequency	Route (by mouth or injection)	Other

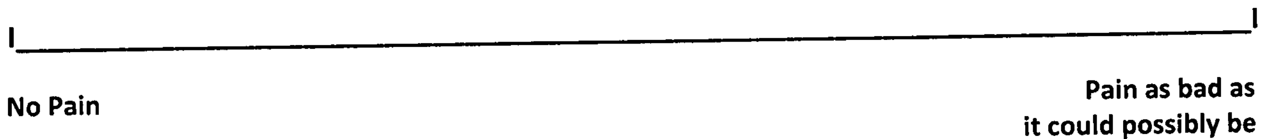
Simple Descriptive Pain Intensity Scale



0-10 Numeric Pain Intensity Scale



Visual Analog Scale (VAS)



Patients Signature: ______________________________

PATIENT INFORMATION

FIRST NAME: ____________ MI: ____ LAST NAME: ____________ DATE: ________
NOMBRE INICIAL APELLIDO FECHA

DATE OF BIRTH: ____________ SOC SEC #: ____________ SEX: ☐ FEMALE ☐ MALE
FECHA DE NACIMIENTO SEGURO SOCIAL SEXO FEMENINO MASCULINO

ADDRESS: ____________ CITY: ____________ STATE: ____ ZIP CODE: ________
DIRECCION CIUDAD ESTADO CODIGO POSTAL

HOME PHONE: ____________ WORK PHONE: ____________ CELL PHONE: ____________
TELEFONO DE CASA TELEFONO DE TRABAJO TELEFONO CELLULAR

E-MAIL ____________
CORREO ELECTRONICO

EMPLOYER: ____________ OCCUPATION: ____________
EMPLEADOR POSICION

EMERGENCY CONTACT ____________ PHONE ____________ RELATIONSHIP ____________
CONTACTO DE EMERGENCIA TELEFONO PARENTESCO

REFERRING DR. / PRIMARY DR: ____________ **PHONE:** ____________
DOCTOR QUE LO REFIERE / MEDICO DE CABECERA TELEFONO

LANGUAGE PREFERENCE: ____________

GUARANTOR & PARTY RESPONSIBLE FOR BILL

FIRST NAME: ____________ MI: ____ LAST NAME: ____________ RELATIONSHIP: ____________
NOMBRE INICIAL APELLIDO PARENTESCO

DATE OF BIRTH: ____________ SOC SEC #: ____________ SEX: ☐ FEMALE ☐ MALE
FECHA DE NACIMIENTO SEGURO SOCIAL SEXO FEMENINO MASCULINO

ATTORNEY NAME: ____________ PHONE NUMBER: ____________

INSURANCE INFORMATION

☐ **MEDICARE** ☐ **MEDICAID** ☐ **AUTO** ☐ **WORKERS' COMP** ☐ **COMMERCIAL** ☐ **SELF PAY**

PRIMARY INSURANCE: ____________
SEGURO PRIMARIO
SECONDARY INSURANCE ____________
SEGURO SECUNDARIO
ATTORNEY NAME: ____________ PHONE NUMBER: ____________

DISCLAIMER AND INFORMED CONSENT

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.
I hereby request and authorize **Physical Therapy Institute and Aquatic Rehab, Inc. / Royal Palm Beach Rehab, Corp. /Action Physical Therapy, Inc.** To perform diagnostic tests and give treatment as deemed necessary. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

PATIENT'S SIGNATURE ____________ **DATE** ____________
FIRMA DEL PACIENTE FECHA

WITNESSED BY ____________ **DATE** ____________
ATESTIGUADO POR FECHA

If the patient is a minor, permission is hereby given by me to the doctors of this office and whomever they designate to treat the patient. I am the patients' legal guardian.

GUARDIAN'S SIGNATURE ____________ **DATE** ____________
FIRMA DEL REPRESENTANTE LEGAL FECHA

Medical History

PATIENT NAME________________________________ DATE ____________

PAST MEDICAL HISTORY - Have you had any of the following symptoms or conditions:

Allergies	YES	NO	Foot Troubles	YES	NO	Rheumatic Fever	YES	NO
Anemia	YES	NO	Gall Bladder	YES	NO	Rheumatoid Arthritis	YES	NO
Asthma	YES	NO	Pacemaker	YES	NO	Severe Headaches	YES	NO
Broken Bones	YES	NO	Head Injury	YES	NO	Shortness of Breath	YES	NO
Cancer	YES	NO	Heart Trouble	YES	NO	Yellow Jaundice	YES	NO
Diabetes	YES	NO	Hernia	YES	NO	Varicose Veins	YES	NO
Ear Trouble	YES	NO	High Blood Pressure	YES	NO	Tumor	YES	NO
Epilepsy	YES	NO	Kidney Trouble	YES	NO	Tuberculosis	YES	NO
Eye Trouble	YES	NO	Mental or Nervous	YES	NO	Skin Conditions	YES	NO
Fainting Spells	YES	NO	Disorders	YES	NO	HIV	YES	NO

Are you presently under a Doctor's care for any condition? YES NO Please Explain ____________

____

Do you have allergies to any medication? YES NO Please Explain ____________

____

Current Subjective Complaints

Date symptoms started : ____________

Please describe your condition and how it happened: ____________

____

What activities if any make your condition better? ____________

____

Date of last X-Rays____________ What body part were taken? ____________

WOMEN ONLY ARE YOU PREGNANT? YES NO Date of last Menstrual Cycle ____________

Please mark the diagram below to point out where your pain is:

HEAD

____ Headaches - How often? ____________

____ Light Headed

____ Double Vision

____ Hearing Loss

____ Memory Loss

____ Ringing in Ears

____ Fainting

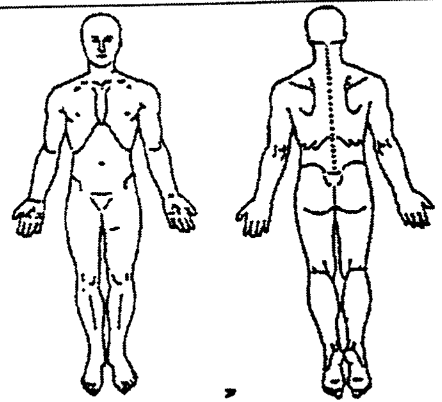
____ Blurred Vision

____ Loss of Balance

____ Dizziness

____ Sensitive to Light

____ TMJ / Jaw Symptoms



Action Physical Therapy Inc-Financial Policy/Assignment of Benefits

Thank you for choosing Action Physical Therapy Inc as your rehabilitation provider. We will work closely with you and your physician to provide you with successful treatment. Please understand that timely payment for your treatment is important. Your clear understanding of our financial policy is important to our professional relationship. Our financial policy is as stated:

- All co-pays & deductibles are due at the time of service
- Payment of patient balances are due in full at the time of service unless other arrangements have been made. If you cannot make full payment at the time of service, please discuss with our Front Office Coordinator.
- We accept cash, checks, Visa, MasterCard, Amex & Discover. There is a $34 return check fee.
- If any portion of your account balance exceeds 60days you may be responsible for the amount regardless of your insurance.

POWER OF ATTORNEY & MEDICAL RELEASE

THIS POWER OF ATTORNEY IS ONLY TO ALLOW US TO ENDORSE AND/OR SIGN ANY PAPER WHICH WILL ENHANCE OR EXPIDITE PAYMENT TO THE PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS OR AUTHORIZATION FOR YOUR INSURANCE/ATTORNEY TO PAY FOR YOUR SERVICES

Know by all these present that: The undersigned has made, constituted & appointed, and by these present does hereby make, constitute & appoint Action Physical Therapy Inc and any of it's duly authorized agents and employees as to be the undersigned's true & lawful attorney for & in the undersigned's name, place & stead to endorse any/all checks, drafts or money order which are made payable to the undersigned alone or to the undersigned and said Action Physical Therapy Inc, when which checks, drafts or money orders are made payable for services which have been rendered by Action Physical Therapy Inc. at the request or with the knowledge and approval of the undersigned and/or the make of the check, draft or money order. Furthermore, the undersigned allows Action Physical Therapy Inc or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include insurance forms and/or other forms.

The undersigned by these present does give & grant the said Action Physical Therapy Inc as attorney the full power and authority to do and perform all & every act whatsoever requisite & necessary to be done in & about the premises as fully to all intents & purposes as the undersigned might or could do It personally insofar as the endorsing & cashing of said checks are concerned as well as any other document.

Medical Release

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services or supplies pertaining to me, the patient, to release true copies of the same to Action Physical Therapy Inc or any insured providing the coverage to me in connection with the process of any claim for benefits made by me or by the assignee herein. A photocopy of the document shall be as binding as an original signature page. The undersigned does hereby ratify and confirm and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these present.

Assignment of Benefits

I, ____, hereby authorize____

(Name of Insured/Patient) (Name of Insurance Carrier)

To make payable directly to: Action Physical Therapy Inc
Payable & mailed directly to: 4971 Le Chalet Blvd. Suite 100, Boynton Beach, FL 33436

The medical benefits otherwise payable to me for their services but not to exceed the charges of those services. I hereby IRREVOCABLY ASSIGN to Action Physical Therapy Inc any right & benefits under any policy of insurance, indemnity, agreement or any other collateral sources as defined in Florida Statutes for any services and/or charges provided by Action Physical Therapy Inc.

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this ____________ day of ____________________.

Signature of Patient (parent/guardian, if minor) ____Date:__________________

Patients Name (Please Print):____

Insurance

We accept Medicare, all major insurances and numerous PPO & managed care contracts. Please be aware that some and perhaps all, of the services provided may be considered not medically necessary by your insurance provider. You will be responsible for these charges.

Your medical insurance is a contract between you and your insurance company. We are not a party to this contract. Action Physical Therapy Inc will submit all claims for charges to your insurance provider as a service to you. Co-pays must be paid at the time of service in order to abide by your insurance contract. If your policy requires a referral, be sure to have it with you when you come to our office. Failure to obtain & present a referral at the time of service may result in a loss of your insurance benefits. If you need assistance in obtaining a referral please ask our Front Desk Coordinator.

Royal Palm Beach Rehab. Corp.-Financial Policy/Assignment of Benefits

Thank you for choosing Royal Palm Beach Rehab. Corp. as your rehabilitation provider. We will work closely with you and your physician to provide you with successful treatment. Please understand that timely payment for your treatment is important. Your clear understanding of our financial policy is important to our professional relationship. Our financial policy is as stated:

- All co-pays & deductibles are due at the time of service
- Payment of patient balances are due in full at the time of service unless other arrangements have been made. If you cannot make full payment at the time of service, please discuss with our Front Office Coordinator.
- We accept cash, checks, Visa, MasterCard, Amex & Discover. There is a $34 return check fee.
- If any portion of your account balance exceeds 60days you may be responsible for the amount regardless of your insurance.

POWER OF ATTORNEY & MEDICAL RELEASE

THIS POWER OF ATTORNEY IS ONLY TO ALLOW US TO ENDORSE AND/OR SIGN ANY PAPER WHICH WILL ENHANCE OR EXPIDITE PAYMENT TO THE PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS OR AUTHORIZATION FOR YOUR INSURANCE/ATTORNEY TO PAY FOR YOUR SERVICES

Know by all these present that: The undersigned has made, constituted & appointed, and by these present does hereby make, constitute & appoint Royal Palm Beach Rehab. Corp. and any of it's duly authorized agents and employees as to be the undersigned's true & lawful attorney for & in the undersigned's name, place & stead to endorse any/all checks, drafts or money order which are made payable to the undersigned alone or to the undersigned and said Royal Palm Beach Rehab. Corp. when which checks, drafts or money orders are made payable for services which have been rendered by Royal Palm Beach Rehab. Corp. at the request or with the knowledge and approval of the undersigned and/or the make of the check, draft or money order. Furthermore, the undersigned allows Royal Palm Beach Rehab. Corp. or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include insurance forms and/or other forms.

The undersigned by these present does give & grant the said Royal Palm Beach Rehab. Corp. as attorney the full power and authority to do and perform all & every act whatsoever requisite & necessary to be done in & about the premises as fully to all intents & purposes as the undersigned might or could do It personally insofar as the endorsing & cashing of said checks are concerned as well as any other document.

Medical Release

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services or supplies pertaining to me, the patient, to release true copies of the same to Royal Palm Beach Rehab. Corp. or any insured providing the coverage to me in connection with the process of any claim for benefits made by me or by the assignee herein. A photocopy of the document shall be as binding as an original signature page. The undersigned does hereby ratify and confirm and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these present.

Assignment of Benefits

I, ______________________________, hereby authorize ______________________________

(Name of Insured/Patient) (Name of Insurance Carrier)

To make payable directly to: Royal Palm Beach Rehab. Corp.

Payable & mailed directly to: 4971 Le Chalet Blvd. Suite 100 Boynton Beach, FL 33436

The medical benefits otherwise payable to me for their services but not to exceed the charges of those services. I hereby IRREVOCABLY ASSIGN to Royal Palm Beach Rehab. Corp. any right & benefits under any policy of insurance, indemnity, agreement or any other collateral sources as defined in Florida Statutes for any services and/or charges provided by Royal Palm Beach Rehab. Corp.

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this __________ day of ________________.

Signature of Patient (parent/guardian, if minor) ______________________________ Date: ______________

Patients Name (Please Print): ______________________________

Insurance

We accept Medicare, all major insurances and numerous PPO & managed care contracts. Please be aware that some and perhaps all, of the services provided may be considered not medically necessary by your insurance provider. You will be responsible for these charges.

Your medical insurance is a contract between you and your insurance company. We are not a party to this contract. Royal Palm Beach Rehab. Corp. will submit all claims for charges to your insurance provider as a service to you. Co-pays must be paid at the time of service in order to abide by your insurance contract. If your policy requires a referral, be sure to have it with you when you come to our office. Failure to obtain & present a referral at the time of service may result in a loss of your insurance benefits. If you need assistance in obtaining a referral please ask our Front Desk Coordinator.

Physical Therapy Institute and Aquatic Rehab Inc-Financial Policy/Assignment of Benefits

Thank you for choosing Physical Therapy Institute and Aquatic Rehab Inc as your rehabilitation provider. We will work closely with you and your physician to provide you with successful treatment. Please understand that timely payment for your treatment is important. Your clear understanding of our financial policy is important to our professional relationship. Our financial policy is as stated:

- All co-pays & deductibles are due at the time of service
- Payment of patient balances are due in full at the time of service unless other arrangements have been made. If you cannot make full payment at the time of service, please discuss with our Front Office Coordinator.
- We accept cash, checks, Visa, MasterCard, Amex & Discover. There is a $34 return check fee.
- If any portion of your account balance exceeds 60days you may be responsible for the amount regardless of your insurance.

POWER OF ATTORNEY & MEDICAL RELEASE

THIS POWER OF ATTORNEY IS ONLY TO ALLOW US TO ENDORSE AND/OR SIGN ANY PAPER WHICH WILL ENHANCE OR EXPIDITE PAYMENT TO THE PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS OR AUTHORIZATION FOR YOUR INSURANCE/ATTORNEY TO PAY FOR YOUR SERVICES

Know by all these present that: The undersigned has made, constituted & appointed, and by these present does hereby make, constitute & appoint Physical Therapy Institute and Aquatic Rehab Inc and any of it's duly authorized agents and employees as to be the undersigned's true & lawful attorney for & in the undersigned's name, place & stead to endorse any/all checks, drafts or money order which are made payable to the undersigned alone or to the undersigned and said Physical Therapy Institute and Aquatic Rehab Inc, when which checks, drafts or money orders are made payable for services which have been rendered by Physical Therapy Institute and Aquatic Rehab Inc. at the request or with the knowledge and approval of the undersigned and/or the make of the check, draft or money order. Furthermore, the undersigned allows Physical Therapy Institute and Aquatic Rehab Inc or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include insurance forms and/or other forms.

The undersigned by these present does give & grant the said Physical Therapy Institute and Aquatic Rehab Inc as attorney the full power and authority to do and perform all & every act whatsoever requisite & necessary to be done in & about the premises as fully to all intents & purposes as the undersigned might or could do it personally insofar as the endorsing & cashing of said checks are concerned as well as any other document.

Medical Release

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services or supplies pertaining to me, the patient, to release true copies of the same to Physical Therapy Institute and Aquatic Rehab Inc or any insured providing the coverage to me in connection with the process of any claim for benefits made by me or by the assignee herein. A photocopy of the document shall be as binding as an original signature page. The undersigned does hereby ratify and confirm and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these present.

Assignment of Benefits

I, ____, hereby authorize____
(Name of Insured/Patient) (Name of Insurance Carrier)

To make payable directly to: Physical Therapy Institute and Aquatic Rehab Inc
Payable & mailed directly to: 4971 Le Chalet Blvd. Suite 100, Boynton Beach, FL 33436

The medical benefits otherwise payable to me for their services but not to exceed the charges of those services. I hereby IRREVOCABLY ASSIGN to Physical Therapy Institute and Aquatic Rehab Inc any right & benefits under any policy of insurance, indemnity, agreement or any other collateral sources as defined in Florida Statutes for any services and/or charges provided by Physical Therapy Institute and Aquatic Rehab Inc.

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this ____________ day of ____________________.

Signature of Patient (parent/guardian, if minor) ____Date:__________________

Patients Name (Please Print):____

Insurance

We accept Medicare, all major insurances and numerous PPO & managed care contracts. Please be aware that some and perhaps all, of the services provided may be considered not medically necessary by your insurance provider. You will be responsible for these charges.

Your medical insurance is a contract between you and your insurance company. We are not a party to this contract. Physical Therapy Institute and Aquatic Rehab Inc will submit all claims for charges to your insurance provider as a service to you. Co-pays must be paid at the time of service in order to abide by your insurance contract. If your policy requires a referral, be sure to have it with you when you come to our office. Failure to obtain & present a referral at the time of service may result in a loss of your insurance benefits. If you need assistance in obtaining a referral please ask our Front Desk Coordinator.

Royal Palm Beach Rehab. Corp., Physical Therapy Institute and Aquatic Rehab, and Action Physical Therapy LLC.

Royal Palm Beach

Notice of Privacy Practices

Date: ______________________________

Patient Name:______________________________

This is to certify that I, ________________________ have been given, offered or have seen the posted copy of the **Notice of Privacy Practices** (also known as HIPAA).

______________________________ ________________

Signature of Patient/Guardian Date

______________________________ ________________

Signature of Clinic representative Date

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Form, but was unable to do so as documented below:

Date:	Initials:	Reason: