PATIENT DEMOGRAPHIC FORM

FLORIDA MOVEMENT THERAPY CENTERS

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ SS #: _____-_____-_____ Gender: Male Female

(Returning Patients) Has your address changed? ☐ Yes ☐ No **If yes, please fill out the below:**

Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Marital Status: Single Married Widowed Divorced Email: _____

Other Address: _____

City: _____ State: _____ Zip Code: _____

Is this condition the result of an accident? (auto, slip and fall, or work related) ☐ Yes ☐ No

PHYSICIAN REFERRAL INFORMATION

Referring Physician: _____ Phone: (_____) _____-_____

How did you hear about us? ☐ Physician ☐ Friend ☐ Ad ☐ Lecture ☐ Internet ☐ Other

EMERGENCY CONTACT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Phone: (_____) _____-_____ Relationship to Patient: _____

As a courtesy all claims will be submitted to your primary and secondary insurance companies and all current guidelines will be followed. There is no absolute guarantee of payment in full by your insurance companies. You will be responsible for any deductibles not met, all co-payments and amounts deemed patient responsibility by your insurance companies. If claims are denied due to incorrect insurance information, patient is financially responsible.

Patient Signature: _____ **Date:** _____

MEDICARE PATIENT FORM

FLORIDA MOVEMENT THERAPY CENTERS

MEDICARE HOME HEALTH

Medicare will not cover Physical, Occupational or Speech Therapy services in our facility if you are having any type of Home Health Care provided by a Medicare Part A Certified Home Health Agency. Home Health Care includes Physical, Occupational and Speech Therapies, Wound Care, Nursing, Aides or Help with Medications. **If you have not been completely discharged by your Home Health Care Agency, you cannot have any Physical, Occupational or Speech Therapy services by Florida Movement Therapy Center – Boynton Beach, LLC.**

Have you had any type of Home Care Therapy in the past 6 months? If yes, please provide the name of the agency used. ☐ Yes ☐ No Name of Agency: _____

Discharge Date: _____

I, _____, understand that Medicare will deny payment for my Physical, Occupational, or Speech Therapy treatments at this clinic if I am under the care of a Medicare Part A Home Health Agency.

Patient Signature: _____ Date: _____

MEDICARE DOLLAR CAP

Effective January 1, 2006 Medicare has placed a dollar amount Cap on therapy services. As of February 2018, the exception process to the Cap was repealed, however, dollar amounts are still being used as a threshold and to elicit a Manual Medical Review, which means that Medicare can withhold payments until they receive documentation from the provider. Medicare will continue to track usage of all therapies each year. The Medicare Part B threshold is $2230 per year for Physical and Speech Therapy combined and $2230 for Occupational Therapy. The Manual Medical Review dollar amount is $3000 for Physical and Speech Therapy combined and $3000 for Occupational Therapy. Chiropractic and Home Therapy Services are not included in the Medicare Cap. **If you have received treatment in another facility and do not inform our office, it will complicate the billing process and possibly lead to a denial from Medicare.**

Have you had any therapy in any other facility since **January 1, 2024**?

Physical Therapy ☐ Yes ☐ No Discharge Date: _____

Speech Therapy ☐ Yes ☐ No Discharge Date: _____

Occupational Therapy ☐ Yes ☐ No Discharge Date: _____

Patient Name: _____ Date: _____

Patient Signature: _____

AUTHORIZATION AND RELEASE OF MEDICAL INFORMATION

I authorize **Florida Movement Therapy Center – Boynton Beach, LLC** to provide therapy treatment by prescription/referral from the referring physician and as established on the plan of care created by the evaluating therapist. I authorize, as well, direct payment of medical bills to **Florida Movement Therapy Center – Boynton Beach, LLC**.

I authorize **Florida Movement Therapy Center – Boynton Beach, LLC** and its therapists to release to my referring physician, any guarantor, my employers, insurance company, or the Social Security Administration or its intermediaries, any information required to secure payment for charges incurred by me or on my behalf including diagnosis of my condition. I include in this information any information regarding HIV or AIDS status, substance abuse and psychiatric history.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

You are entitled to receive a copy of our *Notice of Privacy Practices*. You may ask for a copy of this notice at any time by contacting **Florida Movement Therapy Center – Boynton Beach, LLC** at 561.733.5083..

If you believe your privacy rights have been violated, you may file a complaint with F**lorida Movement Therapy Center – Boynton Beach, LLC** or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, please contact us at **Florida Movement Therapy Center – Boynton Beach, LLC**, 12040 S Jog Rd Ste 8, Boynton Beach, FL 33437. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note that we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Florida Movement Therapy Center – Boynton Beach, LLC**, 12040 S Jog Rd Ste 8, Boynton Beach, FL 33437, 561.733.5083

I have received the right to request a copy of **Florida Movement Therapy Center – Boynton Beach, LLC** Notice of Privacy Practices.

The patient and all involved understand that this signature on file revokes all prior dated signature on file, and they are hereby declared null and void and are substituted by this signature on file.

Patient Name: _____ **Date:** _____

Patient Signature: _____

(Parent or Guardian if patient is a minor)

FLORIDA MOVEMENT THERAPY CENTERS

HIPAA PRIVACY ACKNOWLEDGEMENT AND COMMUNICATION PREFERENCES

For your privacy, please indicate your preferred method for us to communicate confidential medical information, such as test or lab results, to you and/or others involved in your care. Please note that "appointment reminder telephone calls" may be left at the contact number(s) you list below.

PLEASE INDICATE YOUR PREFERENCES FOR LEAVING MESSAGES BELOW:

☐ I prefer and give permission to leave medical information pertaining to me, my dependent or child, by Phone.
☐ I prefer and give permission to leave medical information pertaining to me, my dependent or child, by Text.

Home: (_____) - _____ - _____ Cell: (_____) - _____ - _____

☐ I prefer and give permission to leave medical information pertaining to me, my dependent or child, by Email.

Email: _____

Without specific permission, we will not release any medical information to anyone other than you. In the event we need to speak to someone about your care, please identify those individuals and their relationship to you (i.e. spouse, parent, son, daughter, partner, etc.) below.

☐ DO NOT release medical information to anyone other than myself.
☐ I DO give permission to release medical information pertaining to me to the individuals listed below:

Name of Authorized Person	Phone Number	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name of Authorized Doctors

_____

_____

_____

Patient Name: _____ **Date:** _____

Patient Signature: _____

(Parent or Guardian if patient is a minor)

PATIENT FINANCIAL RESPONSIBILITIES

We appreciate your selection of Florida Movement Therapy Centers as your healthcare provider. Our dedication lies in delivering top-tier therapy services to you. Kindly review and sign this form to confirm your understanding of our patient financial policies.

Financial Responsibility:

_____(*initials*) I acknowledge my responsibility for all charges not covered by my insurance plan, excluding amounts that the Clinic is contractually obligated to waive. This encompasses copays, coinsurances, and applicable deductibles. **I understand that all patient responsibilities must be settled upfront before receiving services.**

Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include:

Charge for returned checks: $25.00

_____(*initials*) I understand that I am responsible for all non-covered services and by signing this form I acknowledge I have been made aware of my obligation prior to receiving such services.

_____(*initials*) I understand that if I do not pay for the charges for which I am responsible the clinic may turn my account over to a collection agency.

Late Cancellation/No Show Policy:

_____(*initials*) I acknowledge that when I schedule an appointment, dedicated time is reserved for me, which cannot be allocated to another patient. Therefore, I understand and accept that Florida Movement Therapy Centers reserves the right to implement the following charges for cancellations and no-shows without a 24-hour notice (*Policy updated on 04/01/2024*) :

Late Cancellations/No Show Fee: $35.00

By signing below, you acknowledge that you have received this notice and understand the policy.

Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____

FLORIDA MOVEMENT THERAPY CENTERS

PATIENT INTAKE FORM

Last Name: _____ First Name: _____

Age _____ Weight: _____ Lbs Height: _____ Ft. _____ Inches. Dominant Hand: Left Right

Briefly describe the problem that brought you in today, how it began, and when.

_____

_____

Have you ever had Physical Therapy, Occupational Therapy for this problem? ☐ Yes ☐ No

Are you receiving any assistance at home in the form of Home Health Care with daily tasks (Home Health Care includes Physical, Occupational and Speech Therapies, Wound Care, Nursing, Aides or Help with Medications) ? ☐ Yes ☐ No

Has the problem changed since it was first notices (e.g. improved or worsened)? □ Yes □ No **(If yes, please describe):**

_____

Medical History: Please check the corresponding box to indicate if you have or have had any of the following conditions.

☐ My Medical History has not changed since the last time I was here

☐ Obesity	☐ Multiple sclerosis	☐ High blood pressure
☐ Pain – Site: _____	☐ Parkinson's Disease	☐ Low blood pressure
☐ Rheumatoid arthritis	☐ Spinal Cord Injury	☐ Asthma/breathing disorders
☐ Osteoarthritis	☐ Traumatic brain Injury	☐ Hearing loss/problems
☐ Osteoporosis/Osteopenia	☐ TIA ☐ CVA	☐ Vision/eye problems
☐ Joint replacement: _____	☐ Cardiac Issues	☐ Weight Loss ☐ Weight Gain
☐ Fractures – site: _____	☐ Bowel/Bladder Dysfunction	☐ HIV/AIDS
☐ Cancer – type _____	☐ Liver Dysfunction	☐ Diabetes Type 1 ☐ Diabetes Type 2
☐ Alzheimer's disease/dementia	☐ High Cholesterol	☐ Neuropathy
☐ Hallucinations	☐ Pulmonary Issues	☐ Immunocompromised System
☐ Memory/ Cognitive Impairment	☐ Fibromyalgia	☐ Other _____

Who do you live with? _____ **Do you have stairs at home?** ☐ Yes ☐ No

Surgical History: Please list any surgeries you have had (Including year).

_____ _____ _____

_____ _____ _____

What do you want to accomplish during Therapy? _____

Are you allergic to latex? ☐ Yes ☐ No **Do you smoke?** ☐ Yes ☐ No **Falls within the last year?** ☐ Yes ☐ No

Do you have a pacemaker or defibrillator? ☐ Yes ☐ No **What is your Occupation?** _____

Medications & Allergies: *Please fill out next page with all medications you are currently taking, or provide us with list to copy.*

☐ I will provide a list of medications ☐ I am not currently taking any medications at this time

☐ (*Existing Patients*) My medications have not changed within the last year

Do you have any medication, food or environmental allergies? ☐ Yes ☐ No **(If yes, please list on following page)**

By signing below I attest that the above is true and correct to the best of my knowledge

Patient Signature: _____ Date: _____

FLORIDA MOVEMENT THERAPY CENTERS

MEDICATION LIST & ALLERGIES

Patient Name:_____ Date Updated:_____

Medication Name (Brand and generic Name)	Dose	*How and How Often do you take these medications*

ALLERGY LIST

1.	*2.*
3.	*4.*
5.	*6.*
7.	*8.*
9.	*10.*
11.	*12.*