

Appt Reminder:  
 Text  
 Call



Insurance: \_\_\_\_\_  
ID#: \_\_\_\_\_  
Phone #: \_\_\_\_\_  
Type of Plan:  
HMO/PPO/POS/MEDICARE/MDCD

PHYSICAL THERAPY  
OCCUPATIONAL THERAPY & SPEECH  
THERAPY

**HOW DID YOU HEAR ABOUT US?:** \_\_\_\_\_

**ARE YOU A FORMER PATIENT OF ASPEN REHAB:** YES NO FIRST VISIT: \_\_\_\_\_

**DIAGNOSIS/CHIEF COMPLAINT:** \_\_\_\_\_

WAS THIS A RESULT OF AN **AUTO ACCIDENT OR INJURY AT WORK:** YES NO

HAVE YOU HAD /ARE YOU RECEIVING **HOME HEALTH THERAPY:** YES NO

IF YES, WHERE? \_\_\_\_\_

**PATIENT NAME:** \_\_\_\_\_ **SOCIAL SEC#:** \_\_\_\_\_

**CAREGIVER:** \_\_\_\_\_ **RELATIONSHIP:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_

**ZIP CODE:** \_\_\_\_\_ **HOME #:** \_\_\_\_\_ **WORK/CELL #:** \_\_\_\_\_

**D.O.B:** \_\_\_\_\_ **E-MAIL:** \_\_\_\_\_

**EMPLOYER:** \_\_\_\_\_ **PH#:** \_\_\_\_\_

**REFERRING PHYSICIAN:** \_\_\_\_\_ **OFFICE #:** \_\_\_\_\_

**EMERGENCY NAME/NUMBER:** \_\_\_\_\_

**AUTO ACCIDENT**

Date of Accident: \_\_\_\_\_ Attorney Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Adjuster Name: \_\_\_\_\_ Adjuster Phone Number #: \_\_\_\_\_

AUTO Insurance Company Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Policy Number #: \_\_\_\_\_

**WORKERS COMPENSATION**

Adjuster Name: \_\_\_\_\_ Phone Number #: \_\_\_\_\_

Workers Comp Company Name: \_\_\_\_\_ Phone Number #: \_\_\_\_\_

Case #: \_\_\_\_\_

**STAFF ONLY: CASE CREATION DATE:** \_\_\_\_\_ **CASE CREATED BY:** \_\_\_\_\_

Patient Name: \_\_\_\_\_

**Patient History Questionnaire**

Is your current condition related to previous Auto or Workmen's Compensation Injury?

Yes \_\_\_ No \_\_\_

Date of your injury/surgery: \_\_\_\_\_ N/A  How did it occur? \_\_\_\_\_

Onset date of your disorder/pain: \_\_\_\_\_ N/A  Have you had this problem before? Yes  No

If yes, when? \_\_\_\_\_ What did the treatment consist of: \_\_\_\_\_

Patient's past medical history: Please check all that apply to you.

- |                            |                          |                                       |                          |
|----------------------------|--------------------------|---------------------------------------|--------------------------|
| Diabetes                   | <input type="checkbox"/> | Pacemaker/ implantable defibrillator? | <input type="checkbox"/> |
| Cancer                     | <input type="checkbox"/> | Hypertension/High Blood Pressure      | <input type="checkbox"/> |
| Heart Disease/Angina       | <input type="checkbox"/> | Shortness of Breath/ Asthma           | <input type="checkbox"/> |
| Allergies (Medication)     | <input type="checkbox"/> | Stroke                                | <input type="checkbox"/> |
| Are you allergic to Latex? | <input type="checkbox"/> | Osteoporosis                          | <input type="checkbox"/> |
| Balance Disorders          | <input type="checkbox"/> | If applicable, are you pregnant?      | <input type="checkbox"/> |
| Other: _____               | <input type="checkbox"/> |                                       |                          |

**Depression Screening:**

1. During the past month, have you often been bothered by feeling down, depressed, or hopeless?  
\_\_\_\_\_
2. During the past month, have you often been bothered by little interest or pleasure in doing things?  
\_\_\_\_\_
3. Are you currently on any medications for depression?  
If so, please list: \_\_\_\_\_

What are your goals in coming to physical therapy? \_\_\_\_\_

How are you limited in your day to day activities? \_\_\_\_\_

Cultural/Religious- Any customs or religious beliefs or wishes that might affect care? \_\_\_\_\_

Occupation: \_\_\_\_\_

Job involves: Prolonged sitting  Prolonged standing/walking  Lifting/climbing/reaching etc...

Do you exercise regularly? Yes  No  If yes, how often? \_\_\_\_\_ How long? \_\_\_\_\_

What type of exercise do you do? \_\_\_\_\_

Do you have difficulty sleeping because of your problem? Yes  No

If yes, number of times you wake up: \_\_\_\_\_ What position do you sleep in: \_\_\_\_\_

Patient Name: \_\_\_\_\_

How do you best learn?    Pictures    Reading    Listening    Demonstration

Other \_\_\_\_\_

Have you had any x-rays, MRI, or other diagnostic tests performed?   Yes    No

If yes, what are the results of the tests:

Please list any surgery you have had and the date(s) of that surgery below:


**PAIN BEHAVIOR:** Please **CHECK** any items below that apply to you.

Aching <input type="checkbox"/>	Throbbing <input type="checkbox"/>	Sharp <input type="checkbox"/>	Dull <input type="checkbox"/>
Nagging <input type="checkbox"/>	Constant <input type="checkbox"/>	On/Off <input type="checkbox"/>	

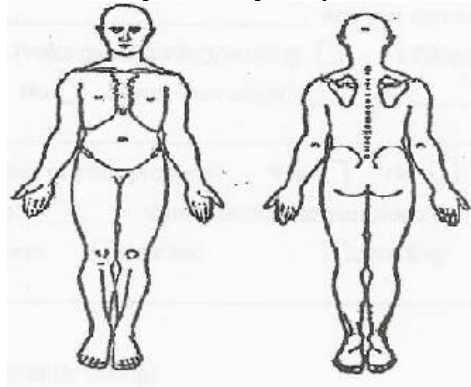
Your pain is worse: Please **CHECK** any items below that apply to you.

Bending <input type="checkbox"/>	Sitting/rising <input type="checkbox"/>	Standing <input type="checkbox"/>	Walking <input type="checkbox"/>	Lying <input type="checkbox"/>
In AM <input type="checkbox"/>	As day progresses <input type="checkbox"/>	In PM <input type="checkbox"/>	At rest <input type="checkbox"/>	On the move <input type="checkbox"/>

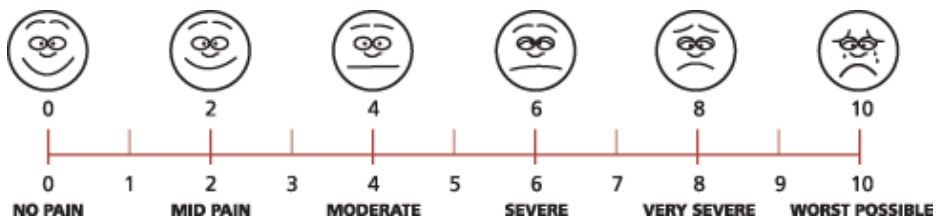
Your pain is better: Please **CHECK** any items below that apply to you.

Bending <input type="checkbox"/>	Sitting/rising <input type="checkbox"/>	Standing <input type="checkbox"/>	Walking <input type="checkbox"/>	Lying <input type="checkbox"/>
In AM <input type="checkbox"/>	As day progresses <input type="checkbox"/>	In PM <input type="checkbox"/>	At rest <input type="checkbox"/>	On the move <input type="checkbox"/>

Mark on the drawing below the areas where you feel your pain.



Please circle the number that reflects your level of pain today.





## AUTHORIZATION AND CONSENT FOR TREATMENT

1. I, the undersigned, acting on my behalf or as the legally authorized representative of patient stated below, do consent for treatment provided by SMART HEALTH SOLUTIONS, P.A. doing business as **Aspen Rehabilitation**. I agree to treatment by its employees, independent contractors, and business associates, which relate to care and treatment as designated. .

2. I understand and acknowledge that I am fully responsible for payment and any charges for care and services provided by Aspen Rehabilitation. I understand and acknowledge that benefits verification done by Aspen Rehabilitation is not a guarantee of payment. Coverage will be determined by your insurance company at the time claims are submitted and according to your policy benefits and provisions. If I am entitled to benefits or insurance of any kind from any policy of insurance, including, but not limited to: Medicare, Personal Injury Protection (PIP), or other auto and liability insurance covering me, or any party liable to me, I authorize payment of these benefits directly to Aspen Rehabilitation. I further understand and acknowledge that Aspen Rehabilitation will bill me for any co-payment and/or balance after my insurance carrier has paid or denied my claim and will be responsible for any balance not paid. I further understand that Aspen Rehabilitation may send any outstanding unpaid balances to a collection agency and/or collections attorney to recover unpaid funds and that the cost of collections and/or legal fees will be included in the outstanding balance owed. \_\_\_\_\_ **(initials)**

Co-pay due each visit \$ \_\_\_\_\_ Co-Insurance due per visit \_\_\_\_\_ %  
Deductible Amount \$ \_\_\_\_\_ Other negotiated pay per visit \$ \_\_\_\_\_

As calculated by your insurance company at the time of you 1<sup>st</sup> visit. This may vary per your insurance calculations.

3. I understand that Aspen Rehabilitation may share my medical information, without my consent or express authorization, to my physician, providers, payers, business associates, and other entities for the purpose of treatment, payment, or healthcare services. My signature below authorizes this sharing of my information and that no information will be shared, used, disseminated, and collected for any other purpose than previously described.

4. I understand that Aspen Rehabilitation will provide therapy services that with diagnosis and treatment may involve risk and injury. I acknowledge that no guarantees have been made to me as a result of examination, care, or treatment. I acknowledge that I have the right to request an explanation of the risks and benefits from services provided.

5. I understand that Aspen Rehabilitation is not legally responsible for the acts and omissions of its independent contractors.

6. I understand that Aspen Rehabilitation's **Cancellation Policy requires 24 hours notice or a \$40 charge** may be imposed. This also applies when I arrive at least 15 minutes late to an appointment. I also understand that not showing for appointments without cancellation on two (2) or more occasions may result in being discharged from therapy services. \_\_\_\_\_ **(initial)**

7. I understand that **Reminder Calls** are courtesy, and are not proof of appointment as appointments may change. I also understand that reminder calls cannot:  
1. Change appointment  
2. Cancel appointment  
\_\_\_\_\_ **(initial)**

8. I understand that if I receive any insurance payments directly from my insurance carrier for services performed, I will immediately (no later than 5 days) pay over such payments to Aspen Rehabilitation. \_\_\_\_\_ **(initial)**

9. I hereby acknowledge that I have received a copy of Aspen Rehabilitation's NOTICE OF PRIVACY PRACTICES for my review, prior to receiving initial services from Aspen Rehabilitation, either now or in the past.

**SIGNED:** \_\_\_\_\_  
(Patient or person legally authorized to consent for patient)

**DATE:** \_\_\_\_\_



PHYSICAL/OCCUPATIONAL/SPEECH  
AESTHETIC SURICAL MANAGEMENT  
9900 W. Sample Rd., Suite 102  
Coral Springs, FL 33065  
Office: (954) 341-7875  
Fax: (954) 341-7895



**Authorization to Release Medical Information/HIPAA Compliance**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I authorize to release/request of my protected health information to/from:

Physician: \_\_\_\_\_

Family Member: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Diagnostic Testing Center: \_\_\_\_\_

Other: \_\_\_\_\_

My information may be released in the form of:  Paper Copy  Electronic Copy

The purpose for this request is to release medical information for:

Medical Care / Treatment  Insurance  Other (Specify): \_\_\_\_\_

I understand that:

- By signing this form, I am authorizing the use or disclosure of protected health information as indicated above.
- I may refuse to sign this authorization, which will not affect my treatment or payment for healthcare.
- I may revoke this authorization at any time before the information I have requested is released by providing written notice of revocation as specified in the Notice of Privacy Practices.
- If the receiving party is not subject to medical records privacy laws, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law. Aspen Rehabilitation shall not be held liable for any consequences resulting from re-disclosure.
- If the information to be released contains any information about HIV/AIDS an additional HIPAA release of medical Information form will be requested.
- Alcohol or substance abuse, mental health or psychiatry notes may have additional compliance requirements that must be met before the information can be released
- A copy of this signed form may be provided to me if I request it.
- Aspen Rehabilitation may charge an administrative fee to cover cost of labor, copying, and postage for any and all medical records. The physician's office will inform me of any charges and arrange for payment.
- This Authorization Expires on \_\_\_\_/\_\_\_\_/\_\_\_\_ (if date not completed/ one year after signed)

Patient/ Representative Signature \_\_\_\_\_ Date: \_\_\_\_\_

## *Cancellation and Discharge Policy*

Should you need to cancel an appointment for any reason, you must provide our office with *24 hours* notice; otherwise, we will be forced to collect a *\$40 cancellation fee* on your next visit. This policy also applies when you are at least 15 minutes late to your appointment. While it is not our desire for our patients to incur additional expenses, we need 24 hours notice to schedule another patient in that time slot. Messages on Voicemail or timed emails can be left for proof of cancellation.

Additionally, if at any point you cancel two or more appointments within a thirty-day period, you may be discharged from the program. This is the only way to ensure that your results are maximized within the allotted time of your course of therapy.

Reminder Calls are courtesy and are not proof of appointment as appointments may change. Reminder calls cannot Change nor Cancel appointments.

We thank you very much for your understanding and cooperation.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_