POLK THERAPY
COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY

295 1st Street, South Ste 2, Winter Haven, FL 33880
250 3rd Street, N.W. Ste 202, Winter Haven, FL 33881
Phone: 863-291-8644 Fax: 863-293-3221

PATIENT INFORMATION

Name: _____ Home Phone: (_____) _____-_____

Address: _____ Cell Phone: (_____) _____-_____

City:_____ State: _____ Zip: _____

Email Address: _____

SS#:_____-_____-_____

Sex □ M □ F Date of Birth: _____/_____/_____ AGE: _____

□ Single □ Married □ Widowed □Separated □ Divorced

In event of emergency contact:_____

Relationship:_____ Phone #:_____

Have you received Physical Therapy this year? **YES NO**

Are you currently receiving Home Health? **YES NO**

Is this <u>WORK</u> related? **YES NO Date of Incident: _____/_____/_____**

Is this <u>AUTO</u> related? **YES NO Date of Incident: _____/_____/_____**

INSURANCE INFORMATION

Primary Insurance: _____Policy#/I.D:_____

Group #_____Policy Holder Name:_____DOB: _____/____/_____

Secondary Insurance: _____Policy#/I.D:_____

Group #_____Policy Holder Name:_____DOB: _____/____/_____

EMPLOYER INFORMATION

Employer

Name:_____Title:_____

Address:_____Phone#:_____

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Personal Medical History **PATIENT NAME:**_____

What is your complaint/ today? _____

Onset/Injury Date: _____/_____/_____

Was a surgical procedure performed? YES NO

If yes:

Surgery Date _____/_____/_____ **Surgical Procedure:**_____

Have you had imaging performed? X-ray. MRI CT Scan Ultrasound Date:___ /____/_____

Other Surgeries & Dates:

Surgical Procedure:_____ **Date**:_____/_____/_____

Surgical Procedure:_____ **Date:**_____/_____/_____

Surgical Procedure:_____ **Date:**_____/_____/_____

Are you currently taking any medications? If yes, please list below: (or provide a copy of all medications)

_____ _____

_____ _____

_____ _____

HAVE YOU EVER BEEN TOLD YOU HAD ONE OF THE FOLLOWING?

Lung Disease	yes	no	High Blood Pressure	yes	no	Seizures	yes	no
Heart Trouble	yes	no	Neurological disorder	yes	no	Depression/Anxiety	yes	no
Pace Maker	yes	no	Cancer	yes	no	Hearing Problems	yes	no
Renal Disease	yes	no	Diabetes	yes	no	Visual Problems	yes	no
Arthritis	yes	no	Liver Disease	yes	no	Hepatitis	yes	no
Allergies	yes	no	Stroke	yes	no	HIV/AIDS	yes	no
Stomach Disorders	yes	no	Circulatory	yes	no	Gland Problems (thyroid)	yes	no

If **yes** to **Cancer** please explain: _____

To the best of my knowledge, the above information is complete and factual.

Signature:_____ **Date**:_____/_____/_____

Patient Signature (Parent or Guardian if patient under 18 yrs)

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SOCIAL SERVICE SCREENING FORM

Polk Therapy LLC is a CORF (Comprehensive Outpatient Rehabilitation Facility). As a CORF, we offer multiple services including, Physical Therapy and Social Services. The following is a questionnaire to determine you potential need for Social Service assistance.

Social History:

Do you have assistance available at home (spouse, child other)?: ▫ Yes ▫ No If "No" Please Explain:_____

_____

Do you have transportation to Physical Therapy? ▫ Yes ▫ No

Do you require Social Service resources for financial assistance in order to achieve maximum response to Physical therapy treatment? ▫ Yes ▫ No If "Yes" Please Explain:_____

Do you have a good support system for daily living? ▫ Yes ▫ NO

Explain:_____

_____ Date: _____/_____/_____

Patient Signature (Parent or Guardian if patient under 18 yrs):

SOCIAL SERVICES SCREEN (to be completed with Physical Therapist)

Patient Reports:

▫ No social services intervention necessary at this point in time.

▫ Social Services evaluation is requested for current emotional/functional distress.

Therapist Assessment:

▫ No Social Services intervention is necessary at this point in time.

▫ Social Services Evaluation is requested for current emotional/functional distress.

Action:

▫ No Social Service intervention necessary_____ Patient refuses Social Service Evaluation.

▫ Referral to Social Services made.

_____ Date____/____/_____

Physical Therapist Signature

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY, PRACTICES, OFFICE POLICIES, PATIENT RIGHTS AND RESPONSIBILITIES, AND FINANCIAL POLICY

Instructions: Please read this form carefully, **initial applicable spaces**, and sign.

Notice: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal Law.

Privacy Policy:

_____**(Initials) HIPAA** – I acknowledge that I was provided a copy of Office Privacy Practices and Office Financial Policies and have received (or had the opportunity to read if I so chose to). I understand the notices provided by Polk Therapy, LLC.

Consent & Treatment:

_____**(Initials)** I consent to *Evaluation and Treatment* by Polk Therapy, LLC and realize that I have the right to refuse any procedure after having the risks and benefits explained to me. I acknowledge that no guarantee or assurance has been made to the results of such treatment, procedures or examinations.

_____**(Initials)** I understand that I am responsible for applicable co-pays, deductibles and co-insurance amounts on date of service. Polk Therapy files insurance as a courtesy to our patients. Discrepancies between the insurance carrier and patient are the responsibility of the patient. Polk Therapy will assist in providing the patient/insured with any available documentation to pursue payment with the insurance carrier in the event of discrepancy of payment.

May we leave appointment reminders on your answering machine/voice mail? □ **Yes** □ **No**

With whom may we leave a message if you are unable to answer**:**

□ **Patient only** □ **Patient/Spouse** □ **Anyone answering the phone**

A Photocopy of these authorizations and agreements shall be as valid as the original.

_____ Date _____/_____/_____

Patient Signature (Parent or Guardian if patient under 18 yrs)

PRINTED NAME: _____

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FINANCIAL POLICIES

Co-pays, deductibles, non-covered services, exclusions, and limited services are due a time of services rendered.

1. **Patients with Medicare** who do not have a secondary insurance will be responsible for their 20% at the time of services, unless other arrangements have been made.
2. **Secondary Insurance:** We will be happy to file your secondary insurance for you.
3. **Cancellation Policy:** There is a 24 hour cancellation policy. Kindly call our office within 24 hours to cancel or reschedule you appointment.
4. **New Patient appointment no shows will be charged a $50.00 fee**
5. **Returned Checks:** A returned check to our office will result in an insufficient funds fee of $35.00.
6. **Change of Information:** If you have any changes in your insurance coverage, name change, etc. it is your responsibility to let us know immediately
7. **Insurance denials/holds:** If your insurance denies, holds, etc. a claim, you will be responsible for the balance.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in the notice while it is in effect. This notice takes effect January 1, 2005 and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information we created or received before we made the changes.
You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies, please contact us using the information listed at the end of this notice.

ASSIGNMENT & RELEASE

I authorize the release of any medical information necessary to process my insurance claim(s). I authorize and request payment of medical benefits directly to Polk Therapy and any assisting physicians, for services rendered. I understand that I am financially responsible for deductible(s), co-insurance and /or co-pay(s) due to contractual obligation with my insurance carrier(s). 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. ***Please sign and date:***

_____ _____ ***Date*** _____/_____/_____

Responsible Party Signature ***Relationship***


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