www.whitesandspt.com

WHITE SANDS PHYSICAL THERAPY

600 Opp Drive
Fort Walton Beach, FL 32548
(850) 301-1935 Fax (850) 301-1937

PATIENT INFORMATION

Name: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Sex: **M/F** Marital Status: **M/S/W/D** Birth Date: _____ SSN: _____

To receive monthly newsletter please provide email address: _____

Employer: _____ Occupation: _____

Address: _____

City: _____ State: _____ Zip: _____

SPOUSE/RESPONSIBLE PARTY

Name: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Birth Date: _____

Employer: _____ SSN: _____

EMERGENCY CONTACT: **PHONE:**

PHYSICIAN INFORMATION

Referring Physician: _____ Was This Due to an Accident: Yes No

If Yes – Auto Worker's Comp Other (Circle One)

Date of Injury/Onset/Surgery: _____

Last Doctor Visit: _____ **Date of Next Doctor Visit:** _____

Authorization to Release Information/Assignment of Benefits/Agreement/Contract

I hereby authorize White Sands Physical Therapy to release to the Insurance company(s) and/or physician any information acquired in the course of my examination or treatment (if patient is a minor, parent/guardian must sign.)

I hereby agree to full responsibility for all expenses incurred by or on account of this patient and hereby assign to White Sands Physical Therapy any and all insurance and settlement benefits due me to the full extent of my financial obligation to said clinic.

I understand my insurance coverage is a relationship between myself and my insurance company and I agree to accept financial responsibility for payment for charges incurred. In the event of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required.

SIGNED: _____ DATE: _____

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Combined Therapy Verification Form
Current Calendar Year

MANY INSURANCE COMPANIES HAVE A COMBINED THERAPY MAXIMUM ALLOWED PER CALENDAR YEAR. THIS IS EITHER LIMITED BY A DOLLAR AMOUNT OR NUMBER OF VISITS ALLOWED PER CALENDAR YEAR. WHITE SANDS PHYSICAL THERAPY WILL MAKE EVERY EFFORT TO STAY WITHIN THE ALLOWED LIMITS. **THEREFORE, WE REQUEST THE FOLLOWING INFORMATION.**

PLEASE INDICATE IF YOU HAVE HAD ANY TREATMENT WITH ANY OF THE FOLLOWING INCLUDING *WHITE SANDS PHYSICAL THERAPY.*

CARDIAC YES_____ NO_____

CHIROPRACTIC YES_____ NO_____

OCCUPATIONAL YES_____ NO_____

SPEECH YES_____ NO_____

PHYSICAL YES_____ NO_____

HOME HEALTH YES_____ NO_____

IN HOSPITAL YES_____ NO_____

NAME OF FACILITY_____

DATES (MM/DD/YYYY) _____

PATIENT SIGNATURE_____

SPECIAL NOTE: YOU CAN NOT DO HOME HEALTH AND OUT PATIENT PHYSICAL THERAPY AT THE SAME TIME.

BLUE CROSS PATIENTS: YOU CAN NOT HAVE PHYSICAL THERAPY AND CHIROPRACTIC SERVICES ON THE SAME DAY. ADDITIONALLY, BOTH PHYSICAL THERAPY AND CHIROPRACTIC ARE A COMBINED SERVICE.

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PATIENT INSURANCE INFORMATION

PRIMARY INSURANCE _____ POLICY # _____

GROUP # _____ SUBSCRIBER NAME _____

SUBSCRIBER DOB _____ RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE _____ POLICY # _____

GROUP # _____ SUBSCRIBER NAME _____

SUBSCRIBER DOB _____ RELATIONSHIP TO PATIENT _____

IF THIS IS A WORKER'S COMPENSATION OR MOTOR VEHICLE CLAIM, PLEASE PROVIDE THE FOLLOWING INFORMATION:

WORKER'S COMP INFORMATION:

EMPLOYER AT TIME OF INJURY _____ DATE OF INJURY _____

WORKERS COMP INSURANCE CO _____ TELEPHONE # _____

CASE WORKER NAME _____CLAIM # _____

MOTOR VEHICLE INFORMATION:

INSURANCE CO _____ POLICY # _____

CLAIM #_____ ADJUSTER NAME_____

TELEPHONE # _____ DATE OF ACCIDENT _____

NAME OF INSURER _____RELATIONSHIP TO PATIENT _____

IS THERE A LAWYER INVOLVED WITH THIS CLAIM? YES _____ NO _____

MPN
Managed Physical Network, Inc.

NAME_____ ADMIT DATE _____ (MONTH DAY YEAR)

ORTHOPEDIC PATIENT HISTORY FORM

NON-PAR PROVIDER FORM

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE. In the space below, please describe the present complaint(s) which brought you to this clinic for care. After completing this first section, please complete the questionnaire on the reverse side. The information you provide concerning past and present symptoms and diseases assists your therapist in obtaining an early understanding of your state of health.

PATIENT HEALTH QUESTIONNAIRE - PAGE 1

1. Present Complaint:_____
   Your goal of therapy: _____
   _____

2. Please describe the character of your current pain (YOU MAY CHECK ONE OR MORE ANSWERS): ☐ Sharp/Stabbing ☐ Sharp/Dull ☐ Aches ☐ Dull ☐ Soreness ☐ Weakness ☐ Throbbing/Gnawing ☐ Numbness ☐ Shooting ☐ Gripping/Constricting ☐ Burning ☐ Tingling

3. How often are the complaints present? ☐ Constant (76–100%) ☐ Frequent (51–75%) ☐ Occasional (26–50%) ☐ Intermittent (25% or less).

4. How bad is your pain or ache? Please circle a number: 0 (NO PAIN) 1 2 3 4 5 6 7 8 9 10 (UNBEARABLE PAIN)

5. Since your problem began is the pain: ☐ Increasing ☐ Decreasing ☐ Not Changing

6. When did your problem begin: SPECIFIC DATE IF POSSIBLE? _____

7. Did your problem begin: ☐ Immediately after a specific incident ☐ Multiple incidents ☐ Gradually developed over time ☐ No specific reason

8. Describe how your problem began: _____
   _____

9. What treatment have you received for this present condition? ☐ Surgery ☐ Injections ☐ Treatment from a Chiropractor ☐ Splint or Brace ☐ Medication(s) _____ ☐ Other _____ If none check here ☐

10. Were you previously treated for a different occurrence of this same condition? ☐ Yes ☐ No. If yes by: ☐ Chiropractor ☐ MD ☐ Therapist ☐ Other _____ (SPECIFY DATES & TYPE OF TREATMENT WITH RESULTS) _____
    _____

11. What makes your problem better? ☐ Nothing ☐ Lying Down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Inactivity ☐ Other _____

12. What makes your problem worse? ☐ Nothing ☐ Lying Down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Inactivity ☐ Other _____

13. How would you grade your general stress level? ☐ Little or No Stress ☐ Minimal Stress ☐ Moderate Stress ☐ Greatly Stressed

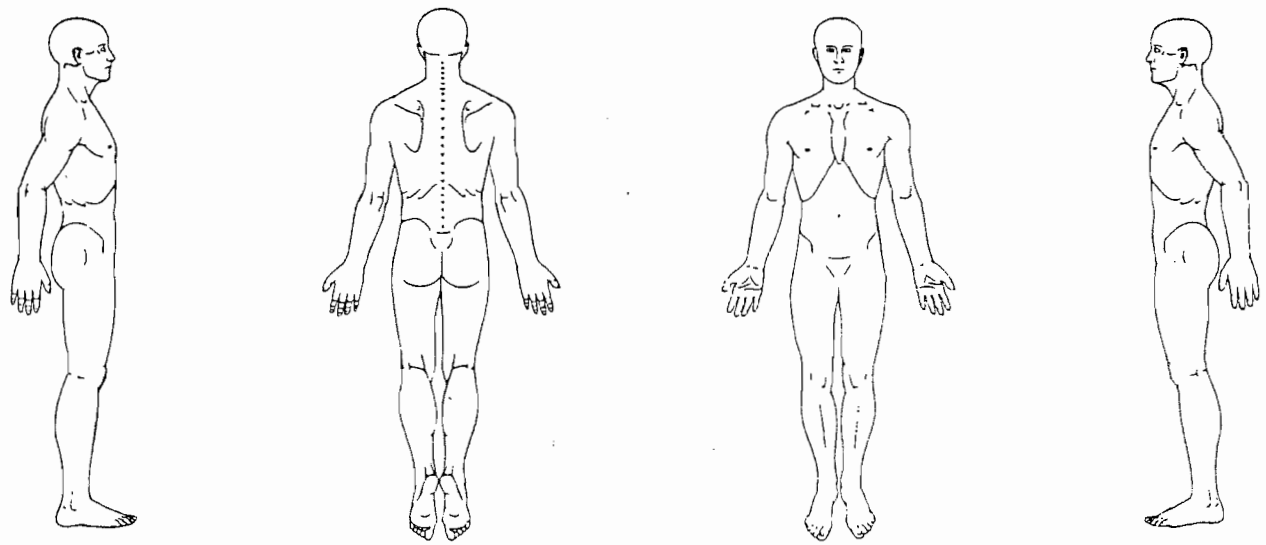
14. Physical activity at work: ☐ Sitting More Than 50% of Workday ☐ Light Manual Labor ☐ Manual Labor ☐ Heavy Manual Labor

15. General physical activity: ☐ No Regular Exercise Program ☐ Light Exercise Program ☐ Strenuous Exercise Program

16. Are your complaints affecting your ability to work or otherwise be active?
    ☐ No effect
    ☐ Some physical restrictions (able to perform light duty work and household tasks).
    ☐ Need limited assistance with common everyday tasks.
    ☐ Need assistance often.
    ☐ Have a significant inability to function without assistance.
    ☐ I am totally disabled (impaired). Cannot care for self.

17. Are you out of work because of this problem? ☐ Yes ☐ No. When do you intend to return to work? _____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS. INCLUDE SYMPTOMS OF PAIN, NUMBNESS OR TINGLING



Patient's Signature:_____ Date:_____

NON-PAR PROVIDER FORM

If you have ever *had* a listed symptom in the *past*, please check that symptom in the *Past column*. If you are *presently* troubled by a particular symptom, check that symptom in the *Present column*. Most manifestation code listings are provided for the therapist's reference.

PATIENT HEALTH QUESTIONNAIRE - PAGE 2

Past	Present	
☐	☐	Neck Pain (723.1)
☐	☐	Shoulder Pain (719.41)
☐	☐	Pain in Upper Arm or Elbow (719.42)
☐	☐	Hand Pain (719.44)
☐	☐	Upper Back Pain (724.1)
☐	☐	Low Back Pain (724.2)
☐	☐	Pain in Upper Leg or Hip (719.45)
☐	☐	Pain in Lower Leg or Knee (729.5)
☐	☐	Pain in Ankle or Foot (719.47)
☐	☐	Jaw Pain (526.9)
☐	☐	Swelling/Stiffness of Joint(s)
☐	☐	Fainting, Visual Disturbances, Nausea (780.2)
☐	☐	Convulsions (780.3)
☐	☐	Dizziness (780.4)
☐	☐	Headache (784.0)
☐	☐	Muscular Incoordination (781.3)
☐	☐	Tinnitus (Ear Noises) (388.30)
☐	☐	Rapid Heart Beat (785.0)
☐	☐	Chest Pains (786.50)
☐	☐	Loss of Appetite (783.0)
☐	☐	Anorexia 783.0
☐	☐	Abnormal Weight ☐ Gain (783.1) ☐ Loss (783.2)
☐	☐	Excessive Thirst (783.5)
☐	☐	Chronic Cough (786.2)
☐	☐	Chronic Sinusitis (473.9)
☐	☐	General Fatigue (780.7)

Past	Present	
☐	☐	Irregular Menstrual Flow (626.4)
☐	☐	Profuse Menstrual Flow (626.7)
☐	☐	Breast Soreness/Lumps (611.72)
☐	☐	Vaginal Discharge (623.5)
☐	☐	PMS (625.4)
☐	☐	Loss of Bladder Control (788.30)
☐	☐	Painful Urination (788.1)
☐	☐	Frequent Urination (788.41)
☐	☐	Abdominal Pain (789.0)
☐	☐	Constipation/irregular bowel habits (564.0)
☐	☐	Difficulty in Swallowing (787.2)
☐	☐	Heartburn/Indigestion (787.1)
☐	☐	Dermatitis/Eczema/Rash (692.9)

Please check any of the following that apply to you.

☐	☐	Tobacco use (305.1)
☐	☐	Alcohol use (305.0)
☐	☐	Birth Control Pills used
☐	☐	Medications (please list them) _____
☐	☐	Drug or Alcohol Dependence (303.9)
☐	☐	Pregnancy
☐	☐	Surgical Procedures (please list them) _____
☐	☐	Coffee/Tea/Caffeinated Soft drinks, cups per day_____

Present: Weight _____ pounds **Height** _____ feet _____ inches

If a family member has had any of the following please mark the appropriate box:

☐ Cancer ☐ Lung Problems ☐ Headaches
☐ Rheumatoid Arthritis ☐ High Blood Pressure ☐ Lupus
☐ Diabetes ☐ Epilepsy ☐ Other Conditions
☐ Heart Problems ☐ Back Problems _____

Yes	No	
☐	☐	Do you have a permanent disability rating?
☐	☐	Location _____
☐	☐	Date rating received ____/____/____
		Rating Percentage _____%

Listed below are common diseases and disorders. Please indicate whether you have had a particular disorder in the past or are presently troubled by a listed disorder.

Past	Present	Condition
☐	☐	Depression (311)
☐	☐	Aortic Aneurysm (441.5)
☐	☐	High Blood Pressure (401.9)
☐	☐	Angina (413.9)
☐	☐	Heart Attack (410.9)
☐	☐	Stroke (436)
☐	☐	Asthma (493.9)
☐	☐	Cancer (199.1)
☐	☐	Prostate Problems (601.9)
☐	☐	Anorexia (783.0)
☐	☐	Blood Disorder (790.6)

Past	Present	Condition
☐	☐	Emphysema (chronic lung disorders) (492.8)
☐	☐	Arthritis (716.9)
☐	☐	Diabetes (250.0)
☐	☐	Ulcer (556.9)
☐	☐	Kidney Stones (592.0)
☐	☐	Bladder Infection (595.9)
☐	☐	Kidney Disorders (by condition)
☐	☐	Colitis (558.9)
☐	☐	Irritable Colon (564.1)
☐	☐	HIV/AIDS (042)
☐	☐	Other_____

Patient's Signature:_____ Date:_____

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PATIENT FINANCIAL GUIDELINES AND RESPONSIBILITIES

It is our desire at White Sands Physical Therapy to make necessary treatment affordable to you. Accordingly, we have established the following guidelines:

We will as a courtesy, verify and process your insurance benefits in our office. **It is your responsibility to furnish all insurance information necessary for processing your claims to the front desk.** Therefore, we will need to make a copy of your insurance card(s). Please note that your insurance coverage is a contract between you and your carrier. **Any deductible, co-insurance, co-pays, and/or service not covered by your insurance carrier is your responsibility and payment will be due at time of service.** It is your responsibility to inform our office of any changes to your insurance plan. Should you have any questions regarding your policy, please contact customer service at the number listed on your card, or bring in your policy booklet and we help to clarify your coverage.

We respect your time and make every effort to remain on schedule. If you arrive late, we may not be able to treat you in full.

Your appointment time has been reserved especially for you. Arriving late or not keeping your appointment increases our costs of providing patient care and eventually our fees. **A 24 hour notice is required if you feel you will not be able to keep your scheduled appointment. A nonrefundable fee in the amount of $100.00 will be charged for 'no shows' or repeated missed appointments without proper notice.**

White Sands Physical Therapy is committed to providing you with the highest quality of care and look forward to having you as a patient.

Robert P. Mann, PT, OCS
Owner, White Sands Physical Therapy Inc.

AGREEMENT: I have read and understand my responsibilities as a patient.

Patient Signature: _____ Date: _____

(Office personnel please initial that a copy was given to patient. _____)

WHITE SANDS PHYSICAL THERAPY, INC.
600 Opp Drive
Fort Walton Beach, FL, 32548
NOTICE OF PRIVACY PRACTICES

Effective Date: 4/14/2003 Updated 10/23/2014

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Each time you visit a physician, hospital, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination, and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. Your record represents Protected Health Information.

We are c*ommitted* to treating and using Protected Health Information about you responsibly. This Notice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your Protected Health Information. This Notice applies to all Protected Health Information, as defined by federal regulations, which is generated by our office.

THE FOLLOWING CATEGORIES DESCRIBE EXAMPLES OF THE WAYS WE USE AND DISCLOSE HEALTH INFORMATION

For Treatment: We may use your health information to provide you with medical treatment or services. We may disclose medical information about you to other health professionals who contribute to your care (such as doctors, nurses, technicians, or other personnel who are involved in taking care of you).

For Payment: We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company, or a third-party payer. For example, we may need to give your insurance company information about your treatment so they will pay us for the treatment. We may also tell your health plan about treatment you are going to receive to determine whether your plan will cover it, unless you exercise your right to restrict**

For Healthcare Operations (Business Associates): There are some services provided in our office through contracts with business associates. Examples include transcription of your dictated health information, a copy service making copies of your health records, e-Prescribing service, a person who provides data transmission services, computer software vendor, and subcontractors that create, receive, maintain or transmit your medical information on behalf of the contracted Business Associate as required by Omnibus HIPAA Rule compliance. When services such as these are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do. To protect your health information, however, we require the business associates to appropriately safeguard your information as required by HIPAA regulations.

Communication with Family or Friend: We may release medical information about you to a friend or family member who is involved in your medical care or who helps pay for your care.

For Research: We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.

For Research, Marketing, Fundraising: Our office does not sell your protected health information. Any activity for research, marketing, fundraising requires your written authorization.

We may also use and disclose medical information to/for the following:

- To remind you that you have an appointment
- Public Health Authorities
- To assess your satisfaction with our services
- Food and Drug Administration
- Organ and Tissue Donation Organizations
- Funeral Directors, Coroners, Medical Directors
- Protective Services for the President of the United States
- Workers Compensation Agents
- Legal Authorities
- Military Command Authorities
- National Security & Intelligence
- Health Oversight Agencies
- To notify or assist in notifying a disaster relief entity so that your family can be notified about your health status for law enforcement purposes as required by law or in response to subpoena

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of this office, you have the right to:

Inspect and Copy: You have the right to view your Protected Health Information, obtain a copy of the information, or both. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. We are allowed to charge you for these copies. If capabilities exist, you may request access to your medical records in electronic format.

Amend: If you feel that medical information is incorrect or incomplete, you may ask us to amend (not change) the information. We may deny your request for an amendment; and if this occurs, you will be notified of the reason for the denial.

An Accounting of Disclosures: You have the right to request a list of certain disclosures we make of your medical information for purposes other than treatment, payment, or healthcare operations.

Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you. We are not required to agree to your request. If we do agree to the requested restriction, it will be honored with the exception of permitted disclosures, including emergency treatment, public health authority, Food & Drug Administration, work-related injury, and OSHA compliance.

**Restricted Disclosure: You have the right to restrict disclosure of your personal protected health information to your health plan/insurance company if that information pertains solely to healthcare for which you (or a person on your behalf) paid for the testing or treatment in full, out of pocket. You must continue to pay out of pocket for subsequent care related to restricted disclosure.

Genetic Information: Your genetic information is treated as Protected Health Information. It cannot be used to discriminate against you for the provision of health insurance or for underwriting purposes.

Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location (for example, at work, or by U.S. Mail). We will grant this request only if it is submitted in writing. We reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response.

Breach: You will be notified within sixty days if a reportable breach of your protected health information occurs.

A Paper Copy of This Notice: You may ask us to give you a copy of this Notice.

<u>If you have any questions about this Notice, please contact our Privacy Officer</u> at this office, telephone: (850) 301-1935

We reserve the right to change this notice and to make the new provisions effective for all Protected Health Information we maintain from the first date of your health record. The current notice will be posted and include the effective date.

If you believe your privacy rights have been violated, you may file a complaint by contacting the Privacy Officer in our office at 600 Opp Drive, Fort Walton Beach, FL, 32548.
All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You may revoke your permission to use or disclose medical information about you, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Please feel free to contact us for more information, or you can get more information about HIPAA or file a complaint to:

White Sands Physical Therapy, Inc.
600 Opp Drive
Fort Walton Beach, FL, 32548
Phone: (850) 301-1935
Fax: (850) 301-1937

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, SW
Washington, D.C., 20201
Phone: (202) 619-0257
Toll Free: (877) 696-6775

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AUTHORIZATION TO RELEASE INFORMATION

The following people named below may obtain medical information for me, and may speak for me if I was to become unable to express my wishes.

NAME: _____ RELATIONSHIP: _____ PHONE: _____

NAME: _____ RELATIONSHIP: _____ PHONE: _____

NAME: _____ RELATIONSHIP: _____ PHONE: _____

I have received a copy of the notice of privacy practice (HIPPA) and I have been provided an opportunity to review it.

NAME: _____ BIRTH DATE: _____

SIGNATURE: _____ DATE: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in the place of the original.

SIGNATURE: _____ DATE: _____
Patient, Parent or Guardian

I hereby authorize ***White Sands Physical Therapy, Inc.*** to apply for benefits on my behalf for covered services rendered. I request that payment from my insurance company be made directly to ***White Sands Physical Therapy, Inc***.

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

SIGNATURE: _____ DATE: _____

Thank you

WEB SITE

www.whitesandspt.com

WHITE SANDS PHYSICAL THERAPY

600 Opp Drive
Fort Walton Beach, FL, 32548
Phone: (850) 301-1935
Fax: (850) 301-1937

Patient Name: _____

Date: _____

PRESCRIBED MEDICATIONS	DOSAGE

OVER THE COUNTER MEDICATION	DOSAGE

SUPPLEMENTS / VITAMINS	DOSAGE