Longwood Rehabilitative Services, Inc.

Orthopaedic Physical Therapy and Wellness Center
2629 W. State Road 434
Longwood, FL 32779
(407) 774-1716
www.longwoodrehab.com

Patient Intake Form

Patient Information Verified DL: ☐Yes ☐ No

Last Name: First Name: Middle Initial:

Address: City: State: Zip Code:

Home Phone: Cell Phone: E-mail Address:

Date of Birth: SSN: Sex: ☐Male ☐Female Marital Status:

Employer Information

Employer Name: Employment Status: ☐Full Time ☐Part Time ☐Retired

Address: City: State: Zip Code:

Work Phone Number: Patient Occupation:

Emergency Contact Information

Contact Name: Phone Number: Relationship to Patient:

Physician Information

Name of Referring Physician:_____ Telephone Number:_____

Family Doctor:_____ Telephone Number:_____

Additional Questions

Auto related:	Work Related:	Accident Related:	Body Part/Diagnosis:	Date of Injury:
☐Yes	☐Yes	☐Yes		
☐No	☐No	☐No		

MEDICARE ONLY- Additional Questions

If Medicare, are you currently receiving Home Health Services? ☐Yes ☐No
If yes, Name of Agency?_____Last date of service:_____
Are you currently residing in a Skilled Nursing Facility?☐Yes☐No If Yes, Name of Facility:_____
If Medicare, have you received PT, OT, or Speech therapy this year? ☐Yes ☐No
If Yes, do you know if you have exceeded your Medicare Therapy Cap amount? ☐Yes ☐No

Patient Signature:_____ Date:__ _____

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MEDICAL HISTORY/SUBJECTIVE INFORMATION

A complete medical history is necessary for a thorough evaluation. Please answer the following questions.

Name: _____ **Date:** _____

Age: _____ **Height:** _____ **Weight:** _____

Tell Us About Your Condition

Where and how did your injury/symptoms occur? ☐ Recreation ☐ Home ☐ Work ☐ Auto Accident ☐ Unknown ☐ Other

What activities are limited by this condition? (E.g. lift, reach) _____

What do you expect to accomplish with physical therapy? _____

Are your symptoms: ☐ Constant? ☐ Increasing? ☐Decreasing?

What makes your symptoms better? _____

Worst pain rating: _____ **Best** pain rating: _____
0-10 pain scale (0 = No Pain; 10 = The Most Extreme Pain)

For this injury, has your medical care included :(check those that apply)

☐Surgery: When? ___/___/___ What kind?_____

☐Injection: When? ___/___/___ Did it Help? ☐ Yes ☐ No

☐Physical therapy If yes, when? ___/___/___to ___/___/__

What was done?_____

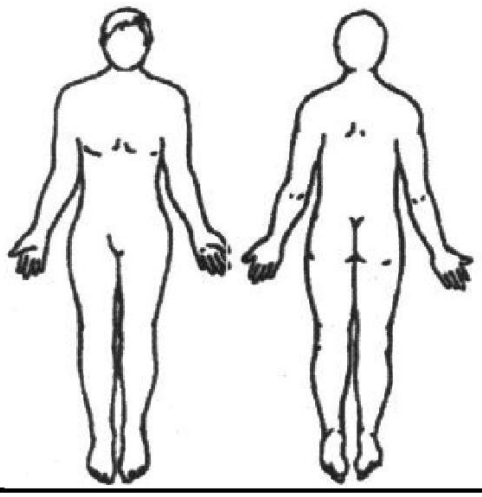
☐Home Health If yes, when? ___/___/___to ___/___/__

☐Chiropractor If yes, when? ___/___/___to ___/___/___

What was done? _____

☐Medications: _____
☐X-ray _____ ☐MRI _____
☐CT scan _____ ☐ Other: _____
Problems with exercise? ☐ No ☐ Yes

Indicate on body diagrams **where** your symptoms are located



Comments: _____

Work Information:

Are you currently working? ☐ No ☐ Yes If yes, numbers of hours per week _____ ☐ Full Duty ☐ Restricted Duty

What are your job responsibilities? _____Estimated return to work date: _____

Additional Comments_____

_____

_____

_____

Patient Signature: _____

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Medical History

Existing or Relevant Previous Conditions:

Allergies	○Yes ○No	Dizzy Spells	○Yes ○No	MRSA	○Yes ○No
Anemia	○Yes ○No	Emphysema/ Bronchitis	○Yes ○No	Multiple Sclerosis	○Yes ○No
Anxiety	○Yes ○No	Fibromyalgia	○Yes ○No	Muscular Disease	○Yes ○No
Arthritis	○Yes ○No	Fractures	○Yes ○No	Osteoporosis	○Yes ○No
Asthma	○Yes ○No	Gallbladder Problems	○Yes ○No	Parkinson's	○Yes ○No
Autoimmune Disorder	○Yes ○No	Headaches	○Yes ○No	Rheumatoid Arthritis	○Yes ○No
Cancer	○Yes ○No	Hearing Impairment	○Yes ○No	Seizures	○Yes ○No
Cardiac Conditions	○Yes ○No	Hepatitis	○Yes ○No	Smoking	○Yes ○No
Cardiac Pacemaker	○Yes ○No	High Cholesterol	○Yes ○No	Speech Problems	○Yes ○No
Chemical Dependency	○Yes ○No	High/ Low Blood Pressure	○Yes ○No	Strokes	○Yes ○No
Circulation Problems	○Yes ○No	HIV/ AIDS	○Yes ○No	Thyroid Disease	○Yes ○No
Currently Pregnant	○Yes ○No	Incontinence	○Yes ○No	Tuberculosis	○Yes ○No
Depression	○Yes ○No	Kidney Problems	○Yes ○No	Vision Problems	○Yes ○No
Diabetes	○Yes ○No	Metal Implants	○Yes ○No		

Describe any other conditions

If "Yes" to Any of the above, please explain and give approximate date /Describe any other Conditions

Fall History

- ○ Injury as a result of a fall in the past year?
- ○ Two or more falls in the last year?
- ○ Patient is at risk for falls?

Surgical History

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Current Medications

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Longwood Rehabilitative Services

FINANCIAL POLICY AGREEMENT

Thank you for choosing Longwood Rehabilitative Services as your healthcare provider. We are committed to the success of your treatment. Please understand that payment of your bill is considered part of your treatment.

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We request that arrangements for payment of your estimated share be made today. Fees for physical therapy services are approximately $75-200 per visit. A print out of charges and payments will be provided upon request. Our practice charges what is usual and customary for our geographic area. In the event your insurance carrier establishes an internal or arbitrary usual and customary fee schedule, you will be responsible for the difference.

Estimated insurance benefit: _____

Estimated patient payment: %: _____ Co-Pay: _____ Deductible: _____

Arrangements for patient's payment: _____

Estimated coverage is provided as a courtesy to our patients. This in no way is intended to release them from the total responsibility of their account balance. If any payment is made directly to you for services billed by Longwood Rehabilitative Services, you recognize an obligation to promptly remit said payment to Longwood Rehabilitative Services.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

Cancellation Policy

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $35.00 per visit. Please help us to serve you better by keeping scheduled appointments. I have read the **Cancellation Policy** _____ (Initial)

I have read and agree to the provisions of this Financial Agreement. I understand my responsibility for the payment of my account.

_____ _____

Patient/Guardian/Responsible Party Date

_____ _____

Company Representative/Witness Date

Longwood Rehabilitative Services

May we text or send you E-Mails to remind you of future appointments?

Please circle one. Text, Y or N, E-Mail, Y or N

May we leave messages about your care on your answering machine? Y or N

May we discuss your care with another person? If yes please the list name,

_____

Please tell us how you heard about Longwood Rehab? _____

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for Longwood Rehabilitative Services, Inc. to furnish physical therapy/health care and treatment to_____considered
(Print Patient Name)
necessary and proper in diagnosing and/or treating his/her physical condition.

PATIENT or GUARDIAN SIGNATURE:_____ DATE:_____

BENEFIT ASSIGNMENT

I, hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and all third party payors to Longwood Rehabilitative Services, Inc. I hereby authorize said assignee to release all information necessary, including Medical records, to secure payment. A photocopy of this assignment is to be considered as valid as the original.

PATIENT/GUARDIAN SIGNATURE:_____ DATE:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing or initialing below, I confirm that I have received a copy of the Notice of Privacy Practices for Longwood Rehabilitative Services, Inc.

PATIENT/GUARDIAN SIGNATURE:_____ DATE:_____