... now I can!
REACTION REHAB™
Physical Therapy

420 South Dixie Hwy, Suite 4D
Coral Gables, FL 33146
t: 305.856.9000
f: 305.856.9910
hello@reactionrehab.com
www.reactionrehab.com

Patient Information Sheet

Please complete the entire form

First Name: ______ Last Name: ______ Initial: ______

Address: ______ Apt: ______

City: ______ State: Florida Zip Code: ______

☎ Home: ______ Work: ______ Cell: ______

Email: ______ Gender: Male ❑ Female ❑

DOB: ______ Social Security Number: ______

Marital Status: Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑

In the case of emergency

Name & Relationship: ______ Name ______ Relation ☎ Number: ______

Care Giver Name: ______ ☎ Number: ______

Insurance

Primary Care Physician: ______ Referring Physician: ______

Primary Insurance Name: ______ Policy Number: ______

Secondary Insurance Name: ______ Policy Number: ______

Accident

Were you involved in an ***ACCIDENT***? Yes ❑ No ❑ Accident Date: ______

Type of accident? Auto Accident ❑ Worker's Compensation ❑ Other ❑

Attorney's Name: ______ ☎ Number: ______

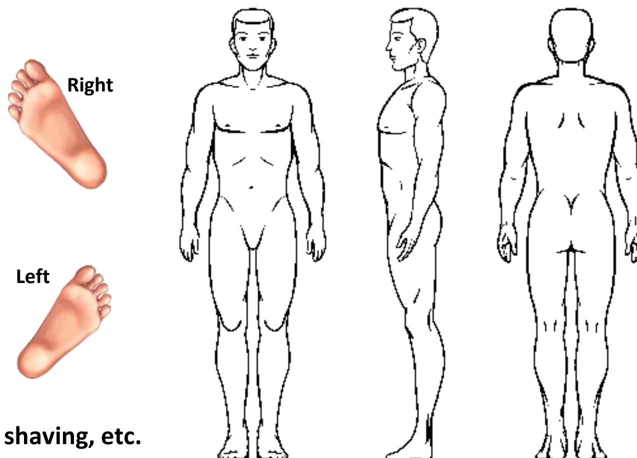
Please Let us Know

What is your **height**? ______ Feet. | Inch. What is your **weight**? ______ Do you have **diabetes**? Yes No

Let us Know about your pain and the area of your pain

Pain Intensity and the area you feel pain the most:

At the office, please rate your pain and show us where it hurts the most



Have you fallen in the past year? Yes No

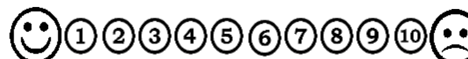
How many times? ______ **Times**

Did you sustain any injuries? Yes No

What is your most significant limitation at this time?

A. **Difficulties walking and moving around**
B. **Difficulties maintaining my balance**
C. **Difficulties carrying, moving, lifting, or handling objects**
D. **Difficulties with self-care such as dressing, eating, showering, shaving, etc.**

Choose only one **My answer is:** E



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Please Let us Know about MEDICATIONS

ARE YOU PRESENTLY TAKING ANY MEDICATIONS: Yes ❑ No ❑

IF YES, PLEASE LIST THEM

	Name	Dosages	Frequency	Route
❶				
❷				

Let us know about your surgeries and hospitalizations

PLEASE LIST ANY MAJOR SURGERIES AND HOSPITALIZATIONS:

❶ ______________________________ Date: __________

❷ ______________________________ Date: __________

❸ ______________________________ Date: __________

PATIENT MEDICAL HISTORY

CHECK IF YOU HAVE EVER HAD (OR SUSPECTED HAVING) ANY OF THE FOLLOWING:

❑ Angina	❑ Emotional Problems	❑ Cancer
❑ Heart Attack	❑ Nervous Problems	❑ High Blood Pressure
❑ Stroke/CVA	❑ Kidney Disease	❑ Lung Disease
❑ Heart Surgery	❑ Gout	❑ Alcohol Abuse Problems
❑ Tumors	❑ Neck Injuries	❑ Jaw Injuries/TMJ
❑ Diabetes	❑ Fractures (broken bones)	❑ Joint Strains
❑ Epilepsy	❑ Back Injuries	❑ Muscle Strains
❑ Arthritis	❑ Dislocation (joints)	❑ Gastrointestinal Problems
❑ Allergies	❑ Whiplash	❑ Heart Disease
❑ Circulatory Problems	❑ Pacemaker	❑ Osteoporosis

CHECK APPROPRIATE BOXES IF YOU HAVE RECENTLY EXPERIENCED:

❑ Headaches	❑ Shortness of breath	❑ Unexplained weight loss
❑ Muscular pain with exertion	❑ Hoarseness	❑ Tingling, numbness
❑ Falls	❑ Dizziness	❑ Loss of feeling
❑ Tremors	❑ Balance Problems	❑ Pain with coughing or sneezing
❑ Muscular pain at rest	❑ Unusual fatigue	❑ Change in bowel/bladder habits
❑ Difficulty sleeping	❑ Unusual weakness	❑ Blurred/double vision
❑ Unusual skin coloration	❑ Constant pain unrelieved by rest/movement	

It is useful for us to know what conditions you or your family members have or have had in the past

Legal stuff

I authorize the release of all medical records and information necessary to process this claim, and I authorize the payment of medical benefits to Reaction Rehab, LLC.

____
Patient's Name (Please Print)

______________________________ Date: __________
Patient's Signature:

Continue to the next page

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Our policies regarding cancellations and no-shows

We take this subject seriously at the clinic because it can make the difference between whether you succeed in your treatment or not.

We require two business days' notice in the event of a cancellation.

There is a $100 cancellation charge without proper notice. This charge will not be covered by insurance, but will have to be paid by you personally.

When you don't show as scheduled, **three people are hurt:**

YOU:	Because you don't get the treatment, you need as prescribed by the Doctor.
PHYSICAL THERAPIST:	Who now has a space in their schedule since the time was reserved for you personally.
ANOTHER PATIENT:	Who could have been scheduled for treatment if you had given proper notice.

Please co-operate with us in this regard. We're looking forward to working with you.

PATIENT'S ACKNOWLEDGEMENT

Patient's Name: ______________________

Patient's Signature: ⊗ ______________________ Date: ______________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, ______________________, have received a copy of this office's Notice of Privacy Practices.
Patient's Name (Please Print)

⊗ ______________________ Date: ______________
Patient's Signature:

For office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communications barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please Specify below)

❶ →

❷ →

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FINANCIAL AUTHORIZATION and ASSIGNMENT OF BENEFITS AGREEMENT

Your insurance policy is a contract between you, your employer, and/or your insurance company. If our office is able to accept your insurance company's assignment, it does not absolve you, the patient, of responsibility for the charges in full for treatment rendered. Please read this form in its entirety prior to signing. Our practice will accept an assignment of benefits from your insurance company with the conditions listed below:

- Although we are willing to complete insurance forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to save your time and to facilitate payment to our practice from your insurance company. By having our practice process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.

- We require you to sign this agreement and/or any other necessary assignment documents that may be required by your insurance company. This instructs you insurance company to make payment directly to our practice.

- We require you to pay the estimated co-insurance, which is the amount not covered by your insurance company, at the time we provide service to you. The co-insurance is only an estimate of charges and may be found to be insufficient after review by your insurance company.

- Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our practice within 60 days, you will be required to pay the entire balance at that time. You will be responsible for seeking reimbursement from your insurance company at that time. **You have the option of being reimbursed directly from your insurance company. If you choose to do so, all fees will be due at the time of service.**

- Our practice does not guarantee that your insurance company will pay for treatment you receive from our practice. It is the patient's responsibility to obtain verification of their insurance plan benefits. Verbal or on-line verification is not a guarantee of payment. Services are subject to limitations and exclusions, including pre-existing conditions, stated in the insurance benefit plan. If your claim is denied, you will be responsible for paying the full amount at that time.

- Our practice will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company to our practice.

- Patients with no Physical or Occupational Therapy insurance are responsible to pay for services in full at the time treatment is rendered, unless prior arrangements have been made in writing.

As of ____________ Total No. of Visit allowed: ____________ This year used: ____________ Co-Pay: $ ____________
NOT CLEAR AT THIS TIME / NOT CLEAR AT THIS TIME / NOT CLEAR AT THIS TIME

Deductible: $ ____________ Deductible Met: $ ____________ Out of Pocket Max: $ ____________ Out of Pocket Max OOP Met: $ ____________
NOT CLEAR AT THIS TIME / NOT CLEAR AT THIS TIME / NOT CLEAR AT THIS TIME / NOT CLEAR AT THIS TIME

Co-Insurance Pt. Portion: % ____________ Ins. Portion: % ____________ Our Fees for Eval: $ ____________ Fee for treatment: $ ____________
NOT CLEAR AT THIS TIME / NOT CLEAR AT THIS TIME / Per 60 Minutes Session / Per 60 Minutes Session

I understand that I will be informed of all treatment and their associated fees prior to initiating Physical or Occupational Therapy. I agree to be responsible for all charges for Physical or Occupational Therapy services provided to me or my dependents. To the extent of the law, I consent to the use and disclosure of my personal health information to carry out payment activities in connection with Physical or Occupational Therapy insurance claims. I agree to pay Reaction Rehab, LLC. and or Rehabilitation Center of Miami, LLC, and its related providers all balances due not payable by insurance of the other payments on my account from the admission date to the date of discharge. In the event that I, the undersigned, receive or come in possession or control of any payment due to Reaction Rehab, LLC. and/or Rehabilitation Center of Miami, LLC, and its related providers from any third-party payer, I agree to pay the same over to Reaction Rehab, LLC. and/or Rehabilitation Center of Miami, LLC, and its related providers. Failure to pay invoice on a timely basis will incur an 18% annual interest rate (1.5% per month). Failure to pay invoices could delay additional services. Client agrees to pay any collection and/or legal fees that the Service Provider incurs in collecting any amounts due from the Client that have not been paid within sixty days of the invoice date.

I HAVE READ AND UNDERSTOOD AND ACCEPT THE TERMS AND CONDITIONS OF THIS ASSIGNMENT OF BENEFITS AGREEMENT. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY PHYSICAL & OCCUPATIONAL THERAPY BENEFITS DIRECTLY TO THE PRACTICE.

Patient: ______________________ ______________________ Date: ____________
Name (Print Please) Signature:

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AUTHORIZATION TO TREAT AND ASSIGNMENT OF BENEFITS

- ***AUTHORIZATION FOR TREATMENT:*** - I hereby authorize the Professional Staff of Reaction Rehab, LLC. and or Rehabilitation Center of Miami, LLC. and related providers to provide treatment, supplies, and equipment. I have been informed of Services and purpose of treatment; common side effects thereof; alternative treatment modalities; approximate length of care; and that consent can be revoked orally or in writing prior to, or during, the treatment period.
- ***ASSIGNMENT OF INSURANCE BENEFITS:*** - For services rendered by Reaction Rehab, LLC. and or Rehabilitation Center of Miami, LLC. and related providers and related providers, I assign the benefits due me under my Insurance Company to reimburse to Reaction Rehab, LLC. and or Rehabilitation Center of Miami, LLC. and related providers for these services. I agree that if these benefits are insufficient to cover the entire company bill and if the illness/disability is not covered by the insurance policy, I will be responsible for payment of the entire company bill or any balance. If I am a private pay patient, I understand that there is no assignment of benefits, and this agreement becomes an authorization to treat only.
- ***FINANCIAL RESPONSIBILITY:*** - I agree to pay Reaction Rehab, LLC. and or Rehabilitation Center of Miami, LLC. and related providers all balances due not payable by insurance of the other payments on my account from the admission date to the date of discharge. In the event that I, the undersigned, receive or come in possession or control of any payment due to Reaction Rehab, LLC. and or Rehabilitation Center of Miami, LLC. and related providers from any third-party payer, I agree to pay the same over to Reaction Rehab, LLC. and or Rehabilitation Center of Miami, LLC. and related providers. Failure to pay invoice on a timely basis will incur an 18% annual interest rate (1.5% per month). Failure to pay invoices could delay additional services. Client agrees to pay any collection and/or legal fees that the Service Provider incurs in collecting any amounts due from the Client that have not been paid within sixty days of the invoice date.
- ***AUTHORIZATION FOR RELEASE OF INFORMATION:*** - I give Reaction Rehab, LLC. and or Rehabilitation Center of Miami, LLC. and related providers to release information as needed to my insurance company and its representatives for the processing of my claim. I also give permission to Reaction Rehab, LLC. and or Rehabilitation Center of Miami, LLC. and related providers to contact my employer to obtain any information relative to insurance benefits if necessary. I understand that this authorization will be valid for seven years from the date of my discharge from Reaction Rehab, LLC. and or Rehabilitation Center of Miami, LLC. and related providers or prior to that upon my written request.
- ***CONSENT OF OUTCOME EVALUATION:*** - I give Reaction Rehab, LLC. and or Rehabilitation Center of Miami, LLC. and related providers authorization to contact me via telephone and mail for up to one year following my discharge. I understand that this will be done in order to determine if the treatment I received had a positive effect.
- ***EMERGENCY MEDICAL CARE:*** - In the event, a life-threatening emergency occurs within the premises of the clinic (or home), in which emergency medical care or treatment is needed, I authorize Reaction Rehab, LLC. and or Rehabilitation Center of Miami, LLC. and related providers to arrange for the care of treatment necessary for my emergency condition. I further authorize the treating facility or medical personnel to provide emergency medical care and treatment and agree to be responsible for medical and related costs as a result of such emergency treatment.

Patient: ______________________ ______________________ Date: __________
Name (Print Please) Signature:

Legal Representative: ______________________ ______________________ Date: __________
Name (Print Please) Signature:

Witness: ______________________ ______________________ Date: __________
Name (Print Please) Signature:

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Consent for Use and Disclosure of Health Information

Purpose: In cases where Reaction Rehab, LLC. and or Rehabilitation Center of Miami, LLC, and its related providers has directed not to rely on Acknowledgements as a basis to use or disclose health information, this form is used to obtain a patient's consent to our use and disclosure of the patient's protected health information to carry out treatment, payment activities, and health care operations, as described more fully in our Notice of Privacy Practices.

SECTION A: PATIENT GIVING CONSENT

First Name: ______________ Last Name: ______________ Initial: ______

Address: ____

Address City: State: Zip Code

☎ Home: ______________ ☎ Cell: ______________

Email: ____

Social Security Number: ______________________________

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

The Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Officer: Carina Wiklund, PT

☎ Telephone: (305) 856-9000 ☎ Fax: (305) 856-9910

Email: Hello@reactionrehab.com

Address: 420 South Dixie Hwy., Suite 4D Coral Gables Florida 33146

Address City State Zip code

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written a notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we had taken in reliance on this Consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, ______________________, have had full opportunity to read and consider the contents of this Consent form and You're Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: ⊗ ______________________ Date: ______________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ______________________

Relationship to Patient: ______________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

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