Cancellations / No-Shows / Late For Appointments

Physical Therapy Appointment Policy

Our Physical Therapy Office/Staff is committed to respecting your valuable time. Our goal is to see you at your scheduled appointment time, every time. In order for us to accomplish this and for us to provide efficient care, we ask for your cooperation with the following policies:

On Time Arrival

Please arrive at, or just before your scheduled appointment time.

Late Arrival

If you arrive late for your appointment, we reserve the right to re-schedule the appointment. Late arrivals will cause a delay in seeing patients who are on time. If you are running late or cannot make your scheduled appointment

Cancellation/Re-Scheduling

We require a 24-Hour Notice for cancelling/changing any appointment. Please contact our office if you need to cancel so that we may be able to fit another patient into that spot. Our clinic is extremely busy so no-shows affect us considerably. We need any and all of the open time available so that we can accommodate all of our patients and so that everyone gets the personalized care that is needed.

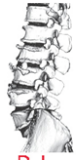
Cell Phones

If you need to keep your cell phone on for emergency purposes only, please put it on vibrate and keep calls to a minimum. Both your time and the therapists' time are important. Please refrain from texting while you are being treated.

We understand that things happen. However, we need to apply these rules so that all of our patients receive the quality of care they deserve. Thank you in advance for your attention. We strive to provide the highest degree of medical care, and will do our best to accommodate you.

____ ____________________

Patient Signature Date



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Patient History

How did the pain start?

- ☐ Suddenly
- ☐ Gradually
- ☐ Lifting
- ☐ No apparent reason
- ☐ Pulling
- ☐ Injured at work
- ☐ Bending
- ☐ Other

What activities make the pain worse?

- ☐ Exercise (during)
- ☐ Exercise (after)
- ☐ Sitting
- ☐ Walking
- ☐ Bending forward
- ☐ Bending backward
- ☐ Coughing
- ☐ Sneezing

What reduces the pain?

- ☐ Lying down
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Anti-inflammatories
- ☐ Pain pills
- ☐ Injection for pain
- ☐ Muscle relaxants
- ☐ Nothing
- ☐ Other

How long have you had this pain?

_______ Years ______ Months _______ Weeks

How long have you had similar pain?

_______ Years ______ Months _____ Weeks

Have you had any of these diagnostic tests?

X-rays	☐ Yes	☐ No	Date _____________
CT scan	☐ Yes	☐ No	Date _____________
EMG/NCV	☐ Yes	☐ No	Date _____________
MRI	☐ Yes	☐ No	Date _____________
Arthrogram	☐ Yes	☐ No	Date _____________
Injections	☐ Yes	☐ No	Date_____________

Have you been hospitalized for your problem?

☐ Yes ☐ No Date: ______________________

Have you had surgery for your problem?

☐ Yes ☐ No Date: ______________________

Have you had any other surgery performed

☐ Yes ☐ No Date: ______________________

Pain/Symptoms

On the Body Diagram to the right, indicate your region of pain using the symbols below:

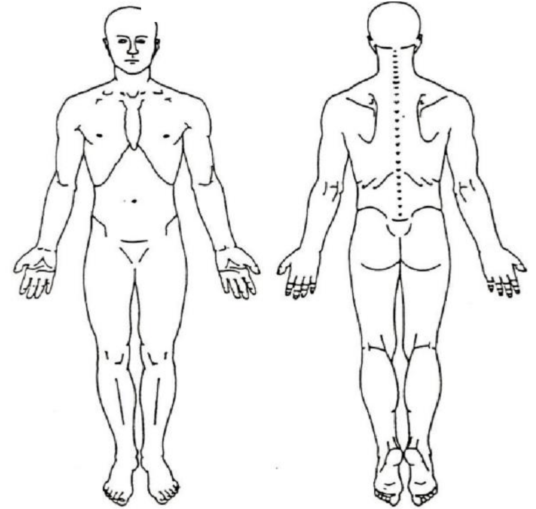
(X) Sharp

(+) Numb/Tingling

(#) Dull/Aching

(B) Burning

Pain Level (0-10): ____



What medications are you currently taking?

____

Yes/No	
☐ ☐	Allergies
☐ ☐	Diabetes
☐ ☐	High blood pressure
☐ ☐	Heart disease
☐ ☐	Stroke (CVA)
☐ ☐	Cancer or tumors
☐ ☐	Lung problems
☐ ☐	Arthritis-joint difficulties
☐ ☐	(Ir)regular headaches
☐ ☐	Dizziness-blackouts
☐ ☐	Seizures-nerve disorders
☐ ☐	Visual Problems
☐ ☐	Menstrual problem
☐ ☐	Immunity disorders
☐ ☐	Gout
☐ ☐	Are you pregnant?
☐ ☐	Joint replacement
☐ ☐	Changes in memory

Yes/No	
☐ ☐	Night sleep disturbance
☐ ☐	Change in bowel or bladder habits
☐ ☐	Change in stool color or rectal bleeding
☐ ☐	Increased thirst of hunger
☐ ☐	Frequent urination
☐ ☐	Indigestion or heartburn
☐ ☐	Nausea or vomiting
☐ ☐	Unusual fatigue-weakness
☐ ☐	Fever or chills
☐ ☐	Frequent or easy bruising or bleeding
☐ ☐	Frequent cramping
☐ ☐	Do you have pain 24 hrs?
☐ ☐	Do you awaken from pain?
☐ ☐	Do you smoke? ____#/Day
☐ ☐	Do you drink? ____#/Day

What other types of doctor / Health care providers have you Seen for this condition?

____

____

____

____

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Personal Information

Who would you like us to contact in case of an emergency:

Name: ____

Relationship: ____

Phone Number: ____

Please list any known allergies:

____

____

List any surgical/medical procedures (Last 5 Years):

____

____

____

List any current Medications/Dosages:

____

____

____

____

____

FINANCIAL AGREEMENT

In consideration of the services rendered by my physician/physical therapist at my request and my direction, I understand I am responsible for, and agree to pay in full all charges incurred for services rendered. I further understand that in the event that a special arrangement has been made to have payment submitted through my insurance company, and the carrier elects not to cover any or all of the claim, I am responsible for the balance in full.

Date: ___________________________________

Print Name: ____

Signature: ____

ComeBack Physical Therapy, Inc. & Gulfstream Outsourcing & Specialized Billing (Go-SB)

In our continued effort to provide our customers with superior service, ComeBack Physical Therapy, Inc. has collaborated with Gulfstream Outsourcing & Specialized Billing (Go-SB). This partnership will allow us to better assist those who have been involved in accidents, and increase the speed at which we process and file insurance claims.

By filling out the attached questionnaire, GO-SB will be able to assist you in the processing of your claim(s). In the event that GO-SB does not receive this information in a timely manner, the payment of these bills may become your responsibility.

Please Print

Patient Information

Last Name: ______________________________ First Name: ______________________________

Address: ____

City: ____________________________________ State: ______ Zip Code: __________________

Tel #: ____________________________________ Cell #: ___________________________________

Email Address:____ SSN: ______________________

Health Insurance Information

Health Insurance Company Name: ____

Policyholder’s (Subscriber’s) Name: ____

Identification Number: ____________________ Group #: ________________________________

Primary Care Physician: ______________________ Telephone: ____________________________

Address: ____

Auto Insurance Information

Vehicle #1 (Vehicle you were in at the time of the accident - PIP)

Auto Insurance Company Name: ______________________ Date of Accident: ________________

Claim #: _____________________________ Adjuster Name: ________________________________

Please indicate if you were a: ☐ Driver/Owner ☐ Driver/Non-Owner ☐ Passenger ☐ Pedestrian

Police report on file? ☐ YES ☐ NO

Insured Name: _______________________________ Policy #: _______________________________

Vehicle #2 (Other Vehicle involved – Bodily Injury)

Auto Insurance Company Name: ____

Claim #: _____________________________ Adjuster Name: ________________________________

Insured Name: _______________________________ Policy #: _______________________________

Worker’s Compensation Information

Company Name: ____________________________ Date of Accident: _________________________

Claim #: ____________________________________ Adjuster Name: __________________________

Employer Name: _____________________________Phone #: ________________________________

Attorney Information

Attorney Name: ________________________________ Phone #: ______________________________

Address: ____

Consent to Disclose Health Information

For Payment, Treatment, and Healthcare Operations

First Name: ___________________________ Last Name: ___________________ MI: ___

Address: (Street) ____

(City): ______________________ State: __________ Zip Code: __________

Date of Birth: _________________________ Home Phone: ________________________

Acknowledgment of Receipt of ComeBack Physical Therapy, Inc's Notice of Privacy Practices

By my signature below, I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for ComeBack Physical Therapy, Inc's, and each of its physical therapists, physical therapist assistants, physician's and other personnel (collectively, "ComeBack Physical Therapy, Inc")

Consent to Disclose My General Health Information:

By my signature below, I hereby consent to ComeBack Physical Therapy, Inc's disclosure of my medical information so that ComeBack Physical Therapy, Inc may treat me, seek payment from third parties for such treatment, and generally carry-on ComeBack Physical Therapy, Inc's health care operations (e.g. quality assurance). I also consent to ComeBack Physical Therapy, Inc when necessary so that these providers may treat me, seek payment for that treatment, and for the purpose of their health care operations.

____ ____________________

Signature of Patient Date

If the patient is emancipated minor or otherwise incapacitated (physically or mentally), obtain the following signatures

______________________________________ _________________________ __________

Signature of Personal Representative Description of Authority Date

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CONSENT TO TREATMENT OF A MINOR

Patients Name: ________________________________DOB: ________________________

I, the undersigned, attest that I am the custodial parent or legal guardian of the above referenced minor, and hereby authorize COMEBACK PHYSCIAL THERAPY, INC, to administer treatment, as it so deems necessary to minor.

Name of custodial parent/ legal guardian: ____

Signature of custodial parent/ legal guardian: ____________________________

Witness: ____________________________

_____/_____/_____

Date

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AFFIDAVIT OF NO MEDICAL INSURANCE

I, ____________________________________, due hereby swear that I have no medical health insurance for payment of medical bills associated with my motor vehicle accident injury. I hereby state that I am not qualified to collect for medical benefits under the policy of any relative with whom I may, or may not, reside with.

____

Print Patient's Name

____

Patient's Signature

____

Date

In witness whereof, undersigned has hereunto set ______________________________________

hand and seal this _____________________ day of ____________________, 20 ___________ .

____

Print Witness' Name

____

Witness Signature

____

Date