FLORIDA SPINE
CHIROPRACTIC & PHYSICAL THERAPY

Welcome to Florida Spine Chiropractic & Physical Therapy! We would like to thank you for making the decision to include us in your rehabilitative journey. The following is some information many of our patients ask about during their first visit. We hope you find answers to some of your questions here, but if not, you're are always welcome to ask us!

Physical Therapy: What to Expect

After an examination that entails us asking several questions on your first visit, your Physical Therapist (PT) will create goals for you to meet throughout your care as well as determine the methods that will be used to best meet these goals. Your PT will use physical treatments, manual therapy, therapeutic exercises, and other techniques specifically catered to your individual needs in order for you to meet *your* goals. Your PT may even assign "homework" – exercises/movements for you to perform on your own at home to improve your outcome in therapy. It is very important that you follow the PT's instructions as compliance is the number one factor determining your success in rehabilitation and wellness. During your time at Florida Spine, your PT will modify and progress your plan of care to ensure your success in treatment. Always notice the changes and continue to follow your PT's instructions. Remember: we want you to get better!

During your treatment at Florida Spine, you will work primarily with the same PT who performed your initial evaluation, Dr. Lisa Weiss PT, DPT. She will be overseeing all of your therapy care including creating your plan of care and progressing you to your functional goals. Please feel free to keep open communication about how you are feeling and improvements in your daily activities so that therapy can be progressed appropriately.

After your first treatment, your body may be sore. **THIS IS NORMAL**. Your Physical Therapy plan may include exercises that work muscles previously not used appropriately, and this may cause slight discomfort. This does not mean you should stop therapy. Inform your PT about any discomforts you may be having before, during, or after your treatment. She may make recommendations on how to manage these issues including altering the plan of care, using ice or heat, or decreasing the exercise load.

Scheduling

Given the one on one care scenario, scheduling in advance is important to ensure you get times that work with your schedule each week. We recommend booking all of your recommended treatment plan appointments after your initial evaluation. Our team will do our very best to work with your schedule as compliance and consistency is again a determining factor in your success.

Insurance: What will they pay? What do I pay? How does it work?

All insurance plans are different. Some plans may cover 100% and others may require co-payments or deductible payments from you. On your first visit we will obtain a copy of your insurance card. Our front office staff will call your insurance company to determine what your coverage is. We will do our best to get information regarding your explanation of benefits by the end of your initial evaluation, or before your second treatment.

It is important that you know physical therapy bills differently than a regular doctor visit. Instead of seeing one charge on your bill, it is possible to see upwards or 4 charges. This is because we must bill in units for each procedure that is performed at each visit. And because you will be progressing each visit, it is likely that we will be doing some different procedures at each appointment, giving you a different charge for each visit.

Florida Spine does offer payment plans. We do this as a service to our patients so that finances do not deter you from obtaining the care that you need.

Florida Spine Physical Therapy New Patient Demographic Sheet

Last Name: _____ First Name: _____ MI._____

Home Phone: _____ Work Phone: _____ Cell: _____

Home Address: _____

City:_____ State: _____ Zip:_____

Date of Birth: ____/____/____ Social Security #: _____-_____-_____ Circle one: MALE FEMALE

Email Address: _____ Spouse Name: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Physician: _____ Phone: _____

How did you hear about Florida Spine? Choose One.

Referred by MD	Previous Patient	Friend:	Phonebook	Internet	Other:

Financial Information (If the patient is a minor, please complete this information)

Name of Responsible Party: _____ Relationship: _____

Home Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Insurance Information (The following section must be filled out COMPLETELY.) I hereby instruct the insurance company below to make payment to Florida Spine.

Primary Insurance: _____ Member ID#: _____

Policy Holder Name: _____ Relationship: _____ DOB:____/____/____

Secondary Insurance: _____ Member ID#: _____

Policy Holder Name: _____ Relationship: _____ DOB:____/____/____

I understand and agree that I am ultimately responsible for the balance of my account for any professional services rendered, regardless of my insurance. I have read all the information above and certify this information is true and correct to the best of my knowledge. I will notify Florida Spine of any changes in my status or the above information. I hereby authorize any treatment(s) agreed upon with the Physical Therapist and physician which are deemed medically necessary.
I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I also authorize Florida Spine, Bryan M. Wells DC, PLLC, and its staff to call my home and leave messages regarding appointments with my spouse and/or on the answering machine. Furthermore, I authorize the use of facsimile transmission, email transmission, internet transmission, and electronic transmission of my personal health information for treatment, payment, and healthcare operations.

Patient or Responsible Party Signature: _____ Date: ____/____/____

DETERMINATION OF PRIMARY PAYOR:

- Have you received **OUT PATIENT THERAPY SERVICES** in the past 12 months?

  PHYSICAL THERAPY: YES NO

  If so, where? _____

  OCCUPATIONAL THERAPY: YES NO

  If so, where? _____

  SPEECH THERAPY: YES NO

  If so, where? _____

- Are you currently receiving or plan on receiving any type of **chiropractic care**? YES NO
- Is Medicare your secondary? YES NO

  If so, please indicate the type by circling below:

Working Age Beneficiary End Stage Renal Disease No Fault Insurance Black Lung

PHC or Other Federal Veteran's Administration Disabled Beneficiary Other_____

- Are you currently receiving, or plan on receiving any type of home health care including nursing and home health aide? YES NO
- Is this injury due to an automobile accident? YES NO
  - If YES, what was date of the accident? _____
  - Is there an attorney involved? _____
- Is this injury work related? YES NO
  - If YES, date of injury? _____
  - What is the employer name and address? _____
- Is your injury the result of any other type of accident? YES NO
  - If YES, please provide details: _____

Patient of Responsible Party Signature: _____ Date: ____/____/____

Florida Spine Chiropractic & Physical Therapy
Bryan M. Wells DC, PLLC
Lisa Weiss PT, DPT

Acknowledgement of Receipt of Notice of Privacy Practices

I understand that as part of my healthcare, this organization originates and maintains my health records describing my health history, symptoms, examination, and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

The patient understands and agrees to allow Florida Spine to use their **Patient Health Information** for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the **privacy of your Patient Health Information**, we encourage you to read the **HIPPA NOTICE** that is available to you at the front desk before signing this consent.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

The following person(s) have my permission to receive my personal health, billing, and appointment information:

_____

_____

Patient or Authorized Signature: _____ **Date:** _____

Print name: _____

FLORIDA SPINE PHYSICAL THERAPY INFORMED CONSENT

A "Physical therapy practitioner" means a physical therapist or a physical therapist assistant who is licensed and who practices physical therapy in accordance with the provisions as defined in the Florida Statute **486.021(7)(2017).**

Before you, the Patient, receive Physical Therapy care, it is important that you read this Consent and understand the nature and risks of Physical Therapy treatment. "Practice of physical therapy" means the performance of physical therapy assessments and the treatment of any disability, injury, disease, or other health condition of human beings, or the prevention of such disability, injury, disease, or other condition of health, and rehabilitation as related thereto by the use of the physical, chemical, and other properties of air; electricity; exercise; massage; the performance of acupuncture only upon compliance with the criteria set forth by the Board of Medicine, when no penetration of the skin occurs; the use of radiant energy, including ultraviolet, visible, and infrared rays; ultrasound; water; the use of apparatus and equipment in the application of the foregoing or related thereto; the performance of tests of neuromuscular functions as an aid to the diagnosis or treatment of any human condition; or the performance of electromyography as an aid to the diagnosis of any human condition only upon compliance with the criteria set forth by the Board of Medicine. **486.021(11)(2017).**

"Physical therapy assessment" means observational, verbal, or manual determinations of the function of the musculoskeletal or neuromuscular system relative to physical therapy, including, but not limited to, range of motion of a joint, motor power, postural attitudes, biomechanical function, locomotion, or functional abilities, for the purpose of making recommendations for treatment. **486.021(10)(2017).**

The undersigned Patient understands and acknowledges the role of a Physical Therapist and that while they are very rare and prevention is emphasized in this practice, there may be risks associated with treatment, which could include thermal injuries, injury associated with joint manipulation, cardiac concerns with exercise, dizziness, bruising, DVT, falls, and others. Practitioners are trained to screen for previous health history for red flags to prevent such risks. The most common side effect following Physical Therapy is delayed onset muscle soreness.

I, also hereby give authorization for **consent of treatment** to **Florida Spine** and whomever they may designate as their assistants to perform and administer therapy and treatment as they deem necessary.

I, the undersigned Patient, understand the risks and limitations associated with the practice of Physical Therapy, including the use of physical evaluation, diagnosis, therapeutic exercise, joint manipulation, manual therapy, and therapeutic modalities such as heat, ice, ultrasound, electric stimulation, traction, and other treatments by Florida Spine. **All of my questions have been answered in detail and I fully understand and certify that no guarantee or assurances have been made to the results or outcome from treatment that may or will be rendered.**

Patient Name (Print): _____

Patient Signature: _____ **Date:** _____

PRE-EXAM FORM: In order to evaluate your condition fully, please be as accurate as possible. Thank you.

PATIENT NAME: _____ AGE: _____ GENDER: ☐M ☐F

OCCUPATION: _____ ARE YOU WORKING NOW? ☐YES ☐NO

1.	Where is your pain/problem?		
2.	What caused your pain/problem?		
3.	Approximately when did it start?		
4.	List ONE activity you are unable to do, that you absolutely want to be able to do again:		
5.	Have you ever had this same (or similar) pain/problem before?	☐ Yes (If yes, when?) ☐ No	
6.	In your understanding, what do you think will make it better?		
7.	How optimistic are you that you'll get better? (Circle one)	Not at all..... Mildly optimistic.....Fairly.....Very.....Extremely	
8.	What are some potential obstacles to you getting better?		
9.	Over the next 30 days, how many hours per week will you commit to getting better?		
10.	What are you expecting from physical therapy?		
11.	On the scale, circle your worst pain level in the past couple of days:	*Mild* *Moderate* *Severe* 0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10	

I understand that my candidacy for a rehabilitation program will be dependent upon my ability and willingness to improve. I have answered the above questions honestly and accurately to the best of my ability. The doctor/therapist will determine whether or not I am a viable candidate for a rehabilitation program and that my approval into their program is not guaranteed.

Patient Signature (or guardian): _____ Date: _____

Patient Name: _____ Patient ID #: _____

MEDICAL HISTORY

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

Describe any other conditions or precautions:

Fall History

Injury as a result of a fall in the past year? O Yes O No Date of Fall:_____

Two or more falls in the last year? O Yes O No Dates of Falls:_____

****** Surgical History**

Body Region: _____ Surgery Type: _____ Date of Surgery: _____/_____ Month / Year

Body Region: _____ Surgery Type: _____ Date of Surgery: _____/_____ Month / Year

Body Region: _____ Surgery Type: _____ Date of Surgery: _____/_____ Month / Year

****** Current Medications** [ ] I do not take any medications [ ] See attached list of medications

Drug: _____ Dosage: _____ Reason for Taking:_____

Drug: _____ Dosage: _____ Reason for Taking:_____

Drug: _____ Dosage: _____ Reason for Taking:_____

Drug: _____ Dosage: _____ Reason for Taking:_____

Patient or responsible party signature_____ Date:_____

Therapist (print) _____ *Therapist (signature)* _____