WHITE SANDS PHYSICAL THERAPY & AQUATICS

MEDICAL HISTORY

Patient Last Name: _____ **First Name**: _____ **DOB:** _____

Primary Care Physician: _____

Referring Physician or name of the doctor who will be signing any reports generated by your therapist: _____

Diagnosis or reason for Physical Therapy: _____

Check all current or past conditions:

Back Pain	☐	Fibromyalgia	☐	Tingling in Legs/Feet	☐
Spinal Stenosis	☐	Hysterectomy	☐	Total Knee Replacement	☐ L ☐ R
Back Surgery	☐	Balance	☐	Total Shoulder Replacement	☐ L ☐ R
Disc Problems	☐	Pregnant	☐	Total Hip Replacement	☐ L ☐ R
History of Sciatica	☐	Asthma	☐	Cancer: Type_____	☐
History of Scoliosis	☐	COPD	☐	Fear of swimming pool	☐
Knee Pain	☐	Shortness of Breath	☐	Open Wound/Sore	☐
Hip Pain	☐	Anxiety	☐	Skin Rashes	☐
Shoulder Pain	☐	Depression	☐	Osteoarthritis (Degenerative)	☐
Neck Pain	☐	Memories Issues	☐	Rheumatoid Arthritis	☐
Neck Stiffness	☐	Dementia	☐	Osteoporosis	☐
Chest Pain	☐	Alzheimer	☐	Osteopenia	☐
Heart Disease Heart Surgery	☐ ☐	Diabetes	Type 1 ☐ Type 2 ☐	Anemia	☐
Pacemaker / Defibrillator	☐	Hypoglycemia	☐	Infection Disease	☐
CVA Stroke	☐	Thyroid	Hypo ☐ Hyper ☐	Vision Problems	☐
High Blood Pressure	☐	Bladder Urgency	☐	DNR	☐
Low Blood Pressure	☐	Bladder Incontinence	☐	Metal Implant	☐
Parkinson	☐	Bowel Urgency	☐		
Headaches	☐	Bowel Incontinence	☐		
Epilepsy or Seizure	☐	Peripheral Neuropathy	☐		
Dizziness/Fainting	☐	Tingling in Arms/Hands	☐		
Falls (last fall date)	☐	Hearing Problems	☐		

Staff Initials: ____

7157 Curtiss Ave.
Sarasota, FL 34231

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Patient Last Name: _____ **First Name**: _____ **DOB:** _____

Do you live alone: ☐ Yes ☐ No Living partner disabled: ☐ Yes ☐ No

Height: _____ Weight: _____

SURGERIES: Please list with Date and Details:

_____

_____

_____

_____

OTHER HEALTH ISSUES (Including Chronic Conditions):

Please list: _____

_____

_____

_____

_____

ALLERGIES:

Please list:_____

_____

☐ I have listed all my medical conditions to the best of my knowledge.

☐ I attest that the information provided by me on this medical history form is correct.

_____ _____

Patient Signature **Date**

Staff Initials: ____

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WHITE SANDS PHYSICAL THERAPY & AQUATICS
MEDICATIONS LIST

Patient Last Name: _____ **First Name**: _____ **DOB:** _____

Please provide us with a complete list of your medications for our files. Please include any Over the Counter medications, Vitamins or Herbal Supplements you may be taking. If you need a second page, please let us know.

	Prescription/Over the Counter/Vitamins Supplements/Herbal Supplements	Dosage	O - Oral I - Injection C - Cream S - Sublingual	Times per day. If only used as needed circle PRN	What is it used for? (i.e.: heart, Blood pressure, kidney)
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					

Check if apply,

☐ I am currently not using any medications.

☐ Please see my list of medications provided on separate page.

☐ I verify that the above list of medications/Supplements is correct and contains all that I am currently taking.

_____ _____

Patient Signature **Date**

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WHITE SANDS PHYSICAL THERAPY & AQUATICS
PATIENT DEMOGRAPHICS

PATIENT INFORMATION (Please Print)

Patient Last Name: _____ **First Name**: _____ **Middle Initial**: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female E-mail: _____

Home Phone: _____ Cell Phone: _____ Social Security #: _____

Address: _____ City: _____State: _____ Zip: _____

Patient Employer: _____ Work Phone: _____

Out of State Address & Phone #: _____

EMERGENCY CONTACT

Name: _____ Home/Cell Phone: _____

Relationship: _____

INSURANCE:

Medicare #: _____Part B Effective Date: _____

Is Medicare your primary insurance Yes ☐ No ☐ If No, which insurance is primary? _____

Insurance Name: _____ Ins ID #: _____Ins Group #: _____

RESPONSIBLE PARTY INFORMATION (Parent/Guardian if patient is a minor)

Name: _____ Home or Cell Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Gender: Male ☐ Female ☐

Authorization to discuss your care with Family or Friends

White Sands Physical Therapy & Aquatics is authorized to discuss health, appointment and/or billing information pertaining to the above patient to the entities below

- Leave information on voice mail: Home ☐ Cell ☐ Work ☐
- Share information to _____ Relationship: _____
- Share information to: _____ Relationship: _____

White Sands Physical Therapy will bill your insurance as a courtesy to you; however, if no payment is received from your insurance within 45 days of billing, payment in full will be expected from you.

I hereby authorize my benefits, including Medicare, to be paid directly to White Sands Physical Therapy and also authorize the release of medical information necessary to process claims.

_____ _____

Patient Signature **Date**

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WHITE SANDS PHYSICAL THERAPY & AQUATICS

Patient Last Name: _____ **First Name**: _____ **DOB:** _____

PHYSICIAN

Date of Next Appointment with Referring Physician: _____

Have you received any physical or speech therapy in this calendar year? Yes ☐ No ☐

How many visits: _____ Place of service: _____ Date of last visit: _____

What area(s) of the body was treated? _____

Have you had medical care in your home in the past 60 days? Yes ☐ No ☐

How many visits: _____If yes, please give date(s): _____

Agency that provided care: _____

*** Medicare will not pay for Outpatient Physical Therapy if patient is receiving any type of Home Health Care. This includes Home Health Nursing, Home Health Respiratory, Home Health Aide, and/or any other type of Home Health Care. It is the patient's responsibility to inform the Therapist or office staff if the patient is currently under Home Health Care. If WSPTA is denied payment because of Home Care Services, then the patient is responsible for the full cost of care provided by WSPTA.**

Patients Initials: _____

ACCIDENT:

Are your symptoms related to an accident? Yes ☐ No ☐ **Auto Accident?** Yes ☐ No ☐

Accident Date: _____ Claim No.: _____

Is the Case Settled? Yes ☐ No ☐

Adjuster Name: _____ Phone No.: _____

Attorney: _____ Phone No.: _____

*** Patient that are scheduled to go in the pool, please be aware, NO OPEN WOUNDS IN THE WATER. If you are to have a biopsy done you will not be able to go into the pool for two weeks after having a biopsy and a written release from your MD will be required to resume pool treatment. We request that for you benefit, all biopsies be scheduled after you have completed therapy (unless otherwise noted by your doctor).**

Patients Initials: _____

*** WSPTA strives to provide the best therapy in the area, any changes in your health while enrolled in our program makes a difference in your care. Please report any falls or injury immediately, your therapist will need to evaluate your condition to make sure that is safe to continue treatment. In the case of a serious injury or fall, a Doctor's note may be required to resume treatment.**

Patients Initials: _____

I attest that the information provided by me on this patient information form is correct.

_____ _____

Patient Signature **Date**

Patient Last Name: _____ **First Name**: _____ **DOB:** _____

Staff Initials: ____

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WHITE SANDS PHYSICAL THERAPY & AQUATICS

Acknowledge of Receipt of Notice of Privacy Practices

I have received or have been offered a copy of the Notice of Privacy Practices from White Sands Physical Therapy & Aquatics.

_____ _____

Patient Signature **Date**

Authorization for treatment, Acknowledgement of Financial Responsibility and Assignment of Benefits

I acknowledge that I am legally responsible for all charges in connection with the medical care, treatment and therapy provided by representatives and personnel of White Sand Physical Therapy & Aquatics, LLC. I consent to the release of any medical information, including diagnosis and the records of any treatment or examination rendered to me for such services to third party payers, health care practitioners and/or managed care organizations. I hereby assign, authorize and direct payment of my medical benefits to White Sands Physical Therapy & Aquatics, LLC. I understand that White Sands Physical Therapy & Aquatics, LLC will assist me in submitting my claims to my insurance carrier. I understand my insurance carrier may not approve or reimburse my medical services in full due to benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand I am responsible for fees not paid in full, co-payments, policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law. Furthermore, any information given to us may be used for the collection of payments for services provided.

_____ _____

Patient Signature **Date**

NO SHOW AND CANCELLATION POLICY

An appointment with a White Sands Physical Therapy and Aquatics therapist reserves a period of time just for you. A cancelled appointment or a no show keeps others from having access to that therapist.

- We require at least 24 hours' notice of cancellation in advance of your scheduled appointment.
- All no shows and late cancellations for appointments will be charged $25.00 for any missed appointment (that includes any portion of your treatment cancelled at the last minute).
- Please cross check your White Sands schedule against your calendar at home for any conflict that would result in a cancellation fee.
- This fee must be paid prior to receiving future services.
- Chronic Cancellations will cause to cancel all patients schedule.
- Medical insurance can not be billed for missed appointments.
- I understand that I must call to cancel my appointment 24 hours prior to my scheduled appointment time. **There will be a $25.00 No call/No show fee assessed when notification is not given for a missed appointment without 24 hours' notice.**

I have read, understand and agree with the provision of this cancellation policy.

_____ _____

Patient Signature **Date**

Staff Initials: ____

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