ENVISION PHYSICAL THERAPY AUTO ACCIDENT/PI INTAKE

Name: _____ Today's Date: _____

Date of Birth: _____ Contact Phone: _____

Address: _____ Email: _____

_____ Emergency Contact: _____

City/State/Zip: _____ Emergency Phone: _____

Date of accident/injury: _____ **Claim #:** _____

Attorney Name: _____ **Attorney Firm:** _____

Attorney Phone: _____

Any previous treatment for this injury? □ No □ Yes Who referred you for PT? _____

Briefly describe your symptoms/reason for your visit: _____

_____

Medical History (please check all that apply):

□ Allergy to Latex, Food, or Medication (specify):
□ Angina/Chest Pain
□ Anxiety and/or Depression
□ Arthritis
□ Asthma or Breathing Difficulties
□ Blood Pressure (specify): High Low
□ Cancer
□ Circulatory Disorder or Peripheral Vascular Disease
□ Defibrillator or Pacemaker
□ Diabetes
□ Fibromyalgia
□ Headaches or Migraines
□ Heart Arrhythmia
□ Heart Disease and/or Heart Attack
□ Hepatitis
□ Hernia(s) or Hernia Repair
□ HIV
□ Joint Replacement and/or Metal Implants
□ Multiple Sclerosis
□ Neuropathy
□ Osteopenia or Osteoporosis
□ Pregnant and/or Breastfeeding (currently)
□ Parkinson 's Disease
□ Scoliosis
□ Seizure(s)
□ Smoker (current)
□ Stroke or TIA
□ Spinal Disk Herniation
□ Spinal Fusion
□ Thyroid Disorder

Please list any hospitalizations, surgical procedures, and current medications: _____

_____

I acknowledge that the health history information provided above is accurate to the best of my knowledge.

Signature: _____ Date: _____

Envision Physical Therapy ● 956 International Parkway, Suite 1580 ● Lake Mary, FL 32746
Ph (407) 936-0314 ●Fax (407) 936-0316 ● Stephanie Baker, PT, Clinic Director

Office of Insurance Regulations

Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form

Personal Injury Protection – Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**
2. I have the right and the **duty to confirm** that the services have already been provided.
3. I was **not solicited** by any person to seek any services form the medical provider of the services described above.
4. The medical provider has **explained** the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

_____ _____ _____

Name *(PRINT or TYPE)* Signature Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and the relevant information has been provided therein. This means that each request for information has been **truthfully, accurately,** and in **a substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that no service has been **upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic tes**t as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)7, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/her **own hand**):*

_____ _____ _____

Name *(PRINT or TYPE)* Signature Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)9b), Florida Statutes.

Note: the original of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may not be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

QIB-B1-1571

ENVISION PHYSICAL THERAPY

FEE SCHEDULE, PAYMENT POLICIES, ASSIGNMENT OF BENEFITS, AND RELEASE OF RECORDS

FEE SCHEDULE:

Physical Therapy Evaluation Low Complexity (97161)	Unit Rate: $250
Physical Therapy Evaluation Med Complexity (97162)	Unit Rate: $250
Physical Therapy Evaluation High Complexity (97163)	Unit Rate: $250
Therapeutic Exercise (97110) 15-minute treatment	Unit Rate: $70
Manual Therapy (97140) 15-minute treatment	Unit Rate: $70
Massage or Corrective Exercise/Wellness 30-minute treatment	Unit Rate: $45

PLEASE REVIEW EACH STATEMENT AND INITIAL TO ACKNOWLEDGE:

CONSENT TO TREATMENT AND RESPONSIBILITY TO NOTIFY PROVIDER OF CHANGES IN CONDITION:
I understand participation in a physical, massage or exercise therapy program carries with it a risk that certain physiological responses may occur. These may include but are not limited to changes in blood pressure, fainting, irregular heartbeat or heart attack. It is my responsibility to communicate to my provider any injury or change in physical condition, including hospitalization or medical procedures, which may affect my ability to participate **prior** to beginning each treatment session. **Initials:** _____

CANCELLATION POLICY: Failure to cancel your scheduled appointment within 24 hours of the appointment time will result in a $35 cancellation fee. If applicable, your insurance company will not be charged for your missed appointment, you will be responsible for payment out of pocket. **Initials:** _____

RIGHT OF REFUSAL: We reserve the right to refuse service to anyone, including any request for treatment outside our scope of practice as well as to anyone under the influence of drugs or alcohol. We also reserve the right to charge for the session time, if above status applies. **Initials:** _____

RELEASE OF RECORDS: I hereby authorize Envision Physical Therapy to release to any attorney, physician, or insurance company, involved in my case, any medical records or other information necessary to process my claim, which will be utilized for the ultimate recovery of benefits related to my injury/illness. **Initials:** _____

ATTORNEY REPRESENTATION FOR AUTO INJURY: I hereby authorize and direct you, my attorney, to pay Envision Physical Therapy from any settlement, judgement, or verdict for any unpaid balances due as the result of services rendered to me related to treatment of injuries, including court time, and/or any costs related to collection attempts related to treatment of injuries sustained by me on (date): _____. **Initials:** _____

I understand the fee schedule for services provided by Envision Physical Therapy. I have read the facility policies, assignment of benefits, and release of records stated above and agree to abide by them.

Print Name: _____

Signature: _____ **Date:** _____

ENVISION PHYSICAL THERAPY

OTHERS INVOLVED IN MY HEALTHCARE

Patient Name: _____ Date of Birth: _____

Employees and its providers of Envision Physical Therapy **MAY DISCUSS** all aspects of my healthcare with:

Print Name: _____ Relationship: _____

Print Name: _____ Relationship: _____

Print Name: _____ Relationship: _____

Print Name: _____ Relationship: _____

As the patient, you may also request that any part of your private health information (PHI) not be discussed with others involved in your care or for notification purposes, this includes family members or friends, as described in the notice of privacy practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician does agree to the restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

Envision Physical Therapy providers or employees **MAY NOT DISCUSS** aspects of my healthcare with:

Print Name: _____ Relationship: _____

Specific restriction: _____

Print Name: _____ Relationship: _____

Specific restriction: _____

Print Name: _____ Relationship: _____

Specific restriction: _____

ENVISION PHYSICAL THERAPY, INC

ASSIGNMENT OF BENEFITS

In exchange for medical services, I hereby assign and transfer any and all insurance policy rights, benefits and causes of action to Envision Physical Therapy, Inc. for services rendered by Envision Physical Therapy, Inc. related to the automobile incident which occurred on or about _____.
This is an assignment of my rights and benefits. I authorize the insurance company to issue payment directly to Envision Physical Therapy, Inc. I also authorize the insurance company to release any information about my policy and claim directly to Envision Physical Therapy, Inc.

Print Name: _____

Signature: _____ **Date:** _____

ENVISION PHYSICAL THERAPY, INC

RECEIPT OF PRIVACY NOTICE

My signature, below, certifies I have received or reviewed a copy of the NOTICE OF PRIVACY PRACTICES.

Patient's Printed Name: _____

Signature: _____

Patient Date of Birth: _____ Today's Date: _____

Comments: _____

_____

ENVISION PHYSICAL THERAPY

Below are the telephone numbers that must be posted by each licensed FQA facility to comply with CORE 408.801(5)(a)1. And 2. See statute below.

The complaint number is our agency toll free # 1-888-419-4356

The abuse line is 1-800-96-ABUSE (962-2873)

CaraLee Starnes, Long term care

408.810(5)(a) On or before the first day services are provided to a client, a licensee must inform the client and his or her immediate family or representative, if appropriate, of the right to report:

1. Complaints. The statewide toll-free telephone number for reporting complaints to the agency must be provided to clients in a manner that is clearly legible and must include the words: "to report a complaint regarding the services you receive, please call toll free 1-888-4119-3456"

2. Abusive, neglectful, or exploitative practices. The statewide toll free telephone number for central abuse hotline must be provided to clients in a manner that is clearly legible and must include the words: "to report abuse, neglect or exploitation, please call toll free 1-888-96-ABUSE (962-2873)." The agency shall publish a minimum.