

## 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):**

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

**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 from 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 <i>(PRINT or TYPE)</i>	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 test** 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 <i>(PRINT or TYPE)</i>	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.

ENVISION PHYSICAL THERAPY

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

FEE SCHEDULE:

Physical Therapy Evaluation Low Complexity (97161), Medium Complexity (97162), High Complexity (97163)	Unit Rate: \$250
Physical Therapy Re-evaluation (97164)	Unit Rate: \$200
Therapeutic Exercise (97110) 15-minute treatment	Unit Rate: \$70
Manual Therapy (97140) 15-minute treatment	Unit Rate: \$70
Neuromuscular Re-education (NMR) (97112)	Unit Rate: \$70
Therapeutic Activity (97530)	Unit Rate: \$70
Gait Training (97116)	Unit Rate: \$70
Ultrasound (97035) or Electrical-Stimulation (G0283)	Unit Rate: \$70

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)**

\_\_\_\_\_

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.