PERSONAL AND CONTACT INFORMATION

NAME (LAST, FIRST, MIDDLE)		NICKNAME	DOB	AGE	☐MALE ☐FEMALE
STREET ADDRESS		CITY	STATE	ZIP CODE	
PRIMARY PHONE	SECONDARY PHONE	EMAIL			
PREFERRED METHOD OF CONTACT ☐CALL ☐TEXT ☐EMAIL ☐OTHER:		EMERGENCY CONTACT (NAME AND PHONE)			
OCCUPATION (CURRENT OR FORMER IF RETIRED OR DISABLED)		CURRENTLY EMPLOYED? ☐YES ☐NO ☐RETIRED ☐DISABLED			

CONDITION / SYMPTOMS

DESCRIPTION AND DURATION OF CONDITION / SYMPTOMS
LIMITATIONS OR ALTERATIONS IN FUNCTION OR LIFESTYLE **DUE TO THIS CONDITION**
CURRENT OR PREVIOUS TREATMENT FOR THIS CONDITION AND EFFECTS / OUTCOMES

MEDICAL HISTORY

PLEASE CHECK ANY CONDITIONS FOR WHICH YOU **HAVE EVER** BEEN DIAGNOSED AND PLEASE PROVIDE ANY RELEVANT DETAILS (USE ADDITIONAL SPACE BELOW IF NEEDED)	
☐ HEART CONDITIONS	☐ TIA
☐ HIGH BLOOD PRESSURE	☐ BRAIN OR SPINAL CORD SURGERY
☐ LOW BLOOD PRESSURE	☐ SEIZURES
☐ ANEURYSMS	☐ PARKINSON'S
☐ TYPE 1 DIABETES	☐ OSTEOPOROSIS
☐ TYPE 2 DIABETES	☐ BULGING OR HERNIATED DISCS
☐ CANCER	☐ JOINT REPLACEMENT
☐ STROKE	☐ METAL HARDWARE
☐ OTHER (OR ADDITIONAL SPACE)	

PRIMARY INSURANCE ☐ MEDICARE ☐ OTHER _____	PRIMARY INSURANCE ID #	PRIMARY INS PHONE # (IF OTHER THAN MEDICARE)
PRIMARY INSURANCE CLAIMS ADDRESS (IF OTHER THAN MEDICARE)		
SECONDARY INSURANCE	SEC INSURANCE ID #	SEC INSURANCE PHONE #
SECONDARY INSURANCE CLAIMS ADDRESS		
IF PATIENT IS NOT THE INSURANCE SUBSCRIBER: SUBSRIBER NAME DATE OF BIRTH		

ASSIGNMENT OF MY INSURANCE BENEFITS TO PAINFREE PHYSICAL THERAPY INC

I hereby instruct and direct my insurance company to pay by check payable and mailed to Painfree Physical Therapy Inc, 9625 Water Fern Circle, Clermont, FL 34711. If my/this current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it to the above address for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY**. This payment will not exceed my indebtedness to Painfree Physical Therapy Inc, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

(Check each box and sign at the bottom)

☐ A photocopy of this Assignment shall be considered as effective and valid as the original.
☐ I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
☐ I authorize the use of this signature on all insurance submissions.
☐ I authorize Painfree Physical Therapy Inc to deposit checks made in my name.
☐ I authorize Painfree Physical Therapy Inc to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
☐ I understand that I am financially responsible for all charges whether or not paid by insurance.

SIGNATURE OF POLICYHOLDER / CLAIMANT / RESPONSIBLE PARTY	DATE

As you work toward improving your health and well-being, I consider it an honor to support you in your work. Every time you schedule an appointment with me, I reserve an entire hour of my time to work exclusively with you, and I value this time. You expect me to keep the appointment, and I expect the same of you. If you are unable to keep an appointment, I ask and expect that you notify our office at least 24 hours (normal business hours of 8-5 M-F, not evenings, weekends, or holidays) prior to your appointment in order to provide us plenty of time to schedule another patient for that hour. Failure to do this results in hardship, loss of time, loss of revenue, and loss of a valuable opportunity for a patient to receive treatment.

By checking each box and signing below, I acknowledge that:

- ☐ My health is entirely my responsibility.
- ☐ Scheduling and keeping my appointments are entirely my responsibility. While the office offers automated appointment reminders to help me, remembering my appointments is entirely my responsibility.
- ☐ If I fail to keep one of my scheduled appointments regardless of the reason without notifying the office at least 24 business hours in advance, I understand that I am responsible for paying the full session fee of $120, which will not be covered by my insurance.
- ☐ I understand that leaving a voice message outside of normal business hours to cancel my appointment that is scheduled for the next business day (e.g., leaving a message on Saturday or Sunday to cancel an appointment scheduled for Monday) does not constitute 24 business hours' notice and will therefore result in my being responsible for paying the full session fee of $120.
- ☐ I understand that repeatedly failing to keep my scheduled appointments without providing sufficient advanced notice will result in my being discharged from this care.

_____ _____/_____/_____

Signature Date

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

We may disclose your health information to coroners or medical examiners.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.

We may contact you by phone, mail, or email. It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity.

In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

➢ You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.

➢ You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

➢ You have the right to inspect and copy your health information.

➢ You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

➢ You have a right to receive an accounting of disclosures of your protected health information made by us.

➢ You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us by calling this office at (352) 396-0350. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints about your Privacy rights, or how we have handled your health information should be directed to our Privacy Officer by calling this office at (352) 396-0350. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Painfree Physical Therapy with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

_____
Patient's Name (print)

_____
Patient's Signature Date

_____
Authorized Facility Signature Date