# Patient Information

Patient's Name:_____ Date of Birth___/___/____

Patient's Address (No., Street): _____

City/State/Zip:_____

Social Security Number:_____-_____-_____

Home Phone: (_____)-_____-_____ Cell Phone: (_____)-_____-_____

Place of Work:_____ Work Phone: (_____)-_____-_____

Email Address: _____

We request your email address in order to provide you with important medical information on a timely basis. We assure you that we will NOT share your email address with any third party.

Referring Physician:_____

Primary Care Physician:_____

Office Phone:_____Office Fax:_____

In case of emergency, who may we contact?_____

Relationship to patient:_____ Cell Phone: _____

Are you currently seeing a Chiropractor? Y N
Have you received Physical Therapy this Year? Y N Date of Injury? _____

Reason for previous Physical Therapy?_____

How long have you had this pain?_____

How did you hear about us?_____

## Insurance Information

Insurance Plan Name:_____ID Number:_____

Policy Group Number: _____ Name of Insured:_____

Address of the Insured:_____

HIPPA CONSENT FORM

This consent Form has been developed in response to regulations set forth under HIPPAA (Health Insurance Portability and Accountability Act). This regulation included Privacy Standards intended to protect your protected health information, included demographic information and medical information related to the past, present or future physical or mental health condition. This information includes information that is collected from you, created or received by a physician or another health care provider and information received from a health plan, an employer or a health care clearinghouse.

Under these regulations, which took effect April 14, 2003, we are asking for your consent to release information for purposes of treatment, payment and our healthcare operations. Please read the following and feel free to ask any questions that you may have.

**Consent for Purposes of Treatment, Payment and Healthcare Operations**

I consent to the use or disclosure of my protected health information by Maya Physical Therapy Association for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that treatment of me by the Program Therapists may be conditioned upon my consent as evidenced by my signature on the document.

I understand I have the right to request a restriction as how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Maya Physical Therapy Inc. is not required to agree to the restrictions that I may request. However, if the Maya Physical Therapy Inc. agrees to a restriction that I request, the restriction that I request, the restriction is binding on the center.

I understand I have the right to review the Maya Physical Therapy Inc. Notice of Privacy Practices prior to signing this document. This Document can be provided to me in writing and is available for my review in the waiting area of the Center and with the Front Office Staff. The Notice of Privacy practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the center. This Notice of Privacy Practices also describes my rights and the Center's duties with respect to my protected health information.

The center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

_____ _____

Witness Date

# Attention: Patients

# Effective Date April 1, 2013

# Maya Physical Therapy Inc.

## Treatment & Cancellation Policy

Your doctor has prescribed Physical Therapy for you. Physical Therapy aims to restore the normal mechanics and functions of your injured body part. This restoration is accomplished by using a variety of treatments, and thus requires consistent attendance recommended by the Physical Therapist. In addition, for the full effect of your therapy to be realized, your treatment plan must be adhered to fully.

If you are unable to keep your appointment or are going to be late, please call our office as soon as possible. This courtesy allows us to be of service to other patients. **A charge of $25.00 may be made for missed appointments. We respectfully request that you give us 24 hours prior notice to any cancelations.**

We are extremely happy that you chose Maya Physical Therapy for your treatment. We will be committed to you and the treatment of your injury. We want to see you return to normal health as quickly as possible, which may be difficult if cancellations or failure to show problems occur.

Thank you.

Please sign below indicating you understand our policy:

_____Date: _____

## Maya Physical Therapy, Inc.

## Assignment of insurance Benefits/Rights, Release and Demand

I, the undersigned patient/insured, knowingly, voluntarily, intentionally and irrevocably assign the rights and benefits of any insurance policy to which I am or may be entitled, including without limitation my automobile insurance, also known as personal injury protection ("PIP") and medical payments/ expense insurance policy to **Maya Physical Therapy, Inc**. I understand it is the intention of the provider to accept this assignment of insurance benefits in lieu of demanding payment at the time medical/dental services are rendered and this document will allow the provider to file suit against an insurance company for payment of the insurance benefits resulting from the automobile accident. The assignment includes overdue payments, interest and any potential claim for common law or statutory bad faith, or other causes of action. The undersigned further directs the insurer to pay the above named healthcare provider directly without including the patient's name of the check. This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. This assignment replaces any prior assignment.

I further herby authorize this provider to release my personal medical/dental information in compliance the Health Insurance Portability Protection Act ("HIPPA") which will remain effective for the purpose of any claim or litigation arising out of this automobile accident.

I certify that I have read and agree to the terms above. I have not been solicited or promised anything in exchange for receiving health care. I agree that the provider's prices for medical services, treatment and/or supplies are reasonable, usual and customary

Date: _____

Patient Name: _____

Patient Signature: _____

# LETTER OF PROTECTION

Maya Physical Therapy and Wellness Center
5745 S University Dr, Davie, FL 33328
O: 954-252-9619 F: 954-252-9620
Mayapt5745@gmail.com

DOL:
Policy No.:
**CLAIM NO.:**

I, (the "Patient") do hereby authorize Maya Physical Therapy and Wellness Center (the "Provider") to furnish my attorney or authorized representative with a full report of the case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident/illness which occurred. Furthermore, I hereby authorize and direct my attorney or authorized representative to pay directly to the Provider such sums as may be due and owing to them for bills associated with professional services they rendered to me and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate them for their services.

I fully understand that I am directly responsible to the Provider for all bills submitted by them for services rendered to me, and that this agreement is made solely for the Provider's additional protection and in consideration of them awaiting payment until the resolution of my claim against any potentially at-fault parties. I further understand that the Provider has informed me that I may be responsible for deductible co-payments and I understand that any such payments are not contingent upon any settlement, claim, judgment, or verdict by which I may eventually recover compensation from.

DATED_____ Patient's Signature _____

The undersigned, being attorney of record or authorized representative for the above-named patient, does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate the Provider. However, the undersigned attorney or authorized representative shall in no way be held personally liable for any such sums owed to the Provider by the Patient and does not guarantee any such payment whatsoever.

DATED_____ Attorney's Signature _____

**PHOTO/VIDEO CONSENT FORM**

I hereby give **MAYA PHYSICAL THERAPY** and all employees and or agents of **MAYA PHYSICAL THERAPY** the right and permission to use and or/publish photographs/videos of me for promotional purposes advertising, publicity or display of use. I also authorize my photos /videos to be posted on social media, such as Facebook, Instragram, Twitter or office's webpage.

Initial the following:

_____Yes, you may use my photos/videos.

_____No, please do not use my photos/videos.

_____

Name of Patient or Parent/Guardian (print name)

_____

Patient or Parent/Guardian (signature)

_____

Date

# MEDICAL HISTORY FORM

Date: ____/_____/_____

Name:

Birthdate: _____/_____/_____

Last First M. I.

| | | |
|---|---|---|
| Age:_____ Sex: ❑ M ❑ F | Height:____Weight: _____ | Date of injury (onset)<br>____/_____/____ |

| | |
|---|---|
| Do you drink alcohol? ❑ No ❑ Yes | Do you smoke or chew tobacco? ❑ No ❑ Yes |

Describe briefly your present symptoms:

On a scale from 1-10 what is your pain level, when it is at its worst?
On a scale from 1-10 what is your pain level, when it is at its best?

What relieves your pain?

How often do you exercise?

Have you had any past medical surgeries or procedures? If so (please specify where, when, & for what reason):

Do you have Arthritis? If so (please specify where):

## CURRENT MEDICATIONS

Drug allergies: ❑ No ❑ Yes

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

| **Name of drug** | **Dose (include strength & number of pills per day)** |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |
| 6. | |
| 7. | |
| 8. | |
| 9. | |
| 10. | |

## PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Diabetes (type) _____
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Thyroid problem
- ❑ Gout
- ❑ Cancer (type) _____
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart attack
- ❑ Chest Pain
- ❑ Numbness or tingling(where)_____
- ❑ Parkinson's
- ❑ Weakness/Fatigue
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts/ Vision Difficulties
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Sleeping problems
- ❑ Frequent Headaches
- ❑ Migraines
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Hearing Difficulties
- ❑ Hepatitis
- ❑ Bowel/bladder problems
- ❑ Incontinence
- ❑ Tuberculosis
- ❑ HIV/AIDS
- ❑ Pacemaker
- ❑ Bronchitis
- ❑ Dizziness or Faintness
- ❑ Vertigo

Other medical conditions (please list):

Are you currently pregnant or breastfeeding? ❑ No ❑ Yes