Patient Medical History

Please fill out completely and sign the bottom.

MaxHealth
Physical Therapy

Name: _____**DOB:** _____ **Referring Physician:** _____

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

Phone Number: _____ **Email:** _____

Emergency Contact: _____ **Phone:** _____

Chief Complaint: _____

Please check if you have any of the following: ☐ **Pacemaker** ☐ **Cancer** _____ ☐ **Aneurysm** ☐ **Torn Retina**

Date of last X-rays: _____ **Results:** _____

Date of last MRI: _____ **Results:** _____

Previous Therapy: ___Y/ N_____ **Please Explain:** _____

Expectation of Therapy: _____

Do you use a cervical pillow: ___Y / N___ **Age of Mattress?** _____

Type of footwear you typically wear: _____

Prior Level of function / activities / exercise: _____

Past Medical History / Surgical History / Chronic Diagnoses / Other Notes (If you are a patient of record, we will have this information on
file. Only list if you are not an existing MAXhealth patient.**):** _____

_____

Medications (If you are a patient of record, we will have this information on file. Only list if you are **not** an existing MAXhealth patient.**)**: _____

_____

Patient Signature: _____ **Date:** _____

3844 Bee Ridge Rd Sarasota, FL 34233 - 6110 53rd Ave E Bradenton, FL 34203 - 7431 Manatee Ave W Bradenton, FL 34209
Office Phone: (941) 315-6182 - Fax: (941) 487-6233

PATIENT INFORMATION

Regaining and maintaining your health is our primary concern. Therefore, we believe a clear understanding of our office policies and other useful information will help you focus on your treatment program without any distractions. For therapy to be successful, your cooperation and compliance are essential.

MaxHealth Physical Therapy

APPOINTMENTS

If you are truly serious about wanting to get better, please make an effort to keep all your appointments. It is the frequency of treatment that makes therapy effective. Missed appointments will slow your recovery. It is not always necessary for you to evenly space your appointments throughout the week, so if you are unable to keep an appointment, you should reschedule for the next available time slot in that week. Normally our therapy is quite enjoyable, however on occasion, you may feel somewhat sore following certain treatments. This is a normal physiological response, and there are specific things we will do on your next visit to help ease this type of discomfort. If you avoid coming in because of soreness, it will take considerably longer for the soreness to go away.

CANCELLATIONS AND NO SHOWS

If you are unable to keep an appointment for any reason, please call our office immediately to re-schedule. The length of our therapy sessions limits the number of patients a provider can see each day, so when a patient skips an appointment or cancels at the last minute, the entire time set aside for treatment remains unused, and your provider does NOT get paid. Please be considerate of your provider's time and call us at least 24 hours prior if you need to reschedule or cancel. We reserve the right to assess a $25.00 charge for an un-kept appointment to partially cover the providers wages and overhead expense for that unused block of time. You may also be relegated to "standby" scheduling or may be discharged from the practice.

SIGN IN

When coming in for therapy, please sign-in with the physical therapy department. We try to honor appointments at their scheduled time so if you are late, your session may be shortened. For scheduling questions, speak with our office personnel or call our office during business hours. On your first visit, it's also a good idea to come fifteen minutes early to fill out paperwork. Please bring your insurance card, picture ID, a list of prescriptions, your referral form, and any X-ray or MRI reports. It is important that you notify us of any changes in your insurance coverage or personal demographics as soon as they occur.

FINANCIAL POLICY

Please note that our office will verify your insurance benefits as a courtesy. Insurance verification is not a guarantee of payment and this office makes no representation regarding coverage, or your payment obligations. It is the patient's responsibility to know their policy coverage and limitations. Please be aware that with few exceptions, you are ultimately responsible for timely payment of all charges (plus any expenses required for collecting delinquent accounts) even if we agree to accept your insurance. You are also responsible for properly managing any limitations imposed by your policy, as well as timely payment of any deductible, co-pay, or co-insurance amounts. Payment is due at the time of service, unless otherwise arranged prior to your appointment.

AFTER YOUR TREATMENT

Please follow the instructions given by your therapist. Compliance with home exercise programs and other therapist recommendations will only help you recover faster. Right now, getting better should be the most important thing in your life. Please make therapy the most important thing you do for the next few weeks by giving 100% to your therapy program. You will be pleasantly surprised by the outcome.

I have read, understand, and agree to the above and pledge my commitment to my therapy program.

_____ _____

Patient Signature Date

Welcome to MAXhealth Physical Therapy and thank you for placing your trust in our providers.

Patient Care Agreement

Patient Name: _____ Date of Birth: _____

By reading and signing this document, I, the undersigned patient (or authorized representative) consent to and authorize the medical care and treatment tendered to the patient as deemed necessary or advisable in the judgment of the MAXHealth ("MAXHealth") physician or other health care provider. I understand that, prior to rendering treatment, the physician or other health care provider will explain my medical care and treatment, including an explanation of treatment alternatives and the risks associated with such treatment. I acknowledge and consent to the following:

1. AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF THIRD-PARTY PAYMENTS: I hereby expressly authorize MAXHealth and all healthcare professionals providing care to release all necessary information to any insurance company, health plan or other entity (third party payor) which may be responsible for paying for my care. I authorize and direct all payors to pay all benefits due for such care directly to MAXHealth and all professionals providing for such care, and I hereby assign such sums to them. I understand this authorization and assignments shall remain valid unless I provide written notice of revocation to MAXHealth and the third-party payor signed and dated by me; however, such revocation shall not be effective as to information released and/or charges incurred prior to such revocation.

2. NOTICES OF PRIVACY PRACTICES: I acknowledge I have received a copy of (or the opportunity to review) MAXHealth's Notice of Privacy Practices on or before the date signed below. A copy of MAXHealth's Notice of Privacy Practices is also located here: www.mymaxdoc.com.

3. PAYMENT FOR SERVICES: I agree to pay MAXHealth for services rendered. If I am insured by a health insurance plan in which MAXhealth/Best Value participates, MAXhealth/Best Value will submit a claim to my insurance carrier. I understand that my insurance coverage is a contract between me and my insurance company, and not MAXHealth. I understand that I am responsible for any charges denied by my insurance carrier along with any charges classified by my insurance carrier as a deductible, co-payment, and/or coinsurance.

By signing this document, I certify that I have read, understand, and agree to its contents and that information provided by me is accurate and complete. A copy of this document may be utilized the same as the original.

_____ _____

Patient / or Representative Signature Date (mm/dd/yyyy)

If not signed by patient, please provide documentation of legal representative status:

Attached: ( ) Do not have copy: ( )

MEDICARE/MEDIGAP CERTIFICAITON FOR PAYMENT
SIGNATURE ON FILE
WAIVER OF LIABLITY

MaxHealth Physical Therapy

(A photocopy of this document shall be considered as effective and valid as the original document)

MEDICARE: I authorize, without any time limit or restrictions, the use and release of any information needed for my care and to file my Medicare claims. I also authorize and direct payment of Medicare benefits be made directly to MAXhealth for services furnished to me. I agree to pay for all charges over any Medicare benefit limit, all charges designated by Medicare as patient responsibility (See ABN), my annual deductible, any co-payment, and any requested non-covered services. I also agree to comply with the required number of physician visits should my treatment extend beyond 60 days.

MEDIGAP: I authorize and direct payment of Medigap benefits be made directly to MAXhealth for services furnished to me, and I also authorize the use and release of any information needed to file my Medigap claims. **I also agree to be responsible for any unpaid deductible or co-payment at time of service if my secondary insurance (Medigap) is not an automatic rollover.**

SIGNATURE ON FILE: I authorize MAXhealth or its billing agent to file any Medicare, Medigap, third-party, or insurance claim on my behalf to any entity involved with my treatment or payment charges. I again authorize and direct payment of Medicare, Medigap, third-party, or other insurance benefits be made directly to MAXhealth. This is a direct assignment of my rights and benefits under any insuring entity considered to be responsible for payment of my health care services.

WAIVER OF LIABLITY: I also willingly agree to hold harmless and indemnify MAXhealth Physical Therapy and further direct any convening authority or court with legal jurisdiction to summarily dismiss any claim(s) against MAXhealth Physical Therapy that may arise as a result of my treatment or visits to MAXhealth Physical Therapy.

This is a waiver of all rights to sue except for claims of malpractice which may only be brought against individual therapists (not MAXhealth Physical Therapy, its officers, or employees). If any provision of this document is ruled invalid, the remainder shall remain in effect. This document shall apply at all MAXhealth Physical Therapy locations, and a photocopy shall be considered as effective and valid as the original document. **I have read, thoroughly understand, and agree to the above.**

BY INITIALING, I CERTIFY I AM NOT UNDER THE CARE OF ANY HOME HEALTH AGENCY, OR ANY OTHER PROVIDER THAT WOULD PREVENT PAYMENT FOR MY CARE HERE. I AGREE TO BE FINANCIALLY RESPOSIBLE FOR ANY COSTS INCURRED IN THE EVENT THAT MY INSURANCE PROVIDER DENIES PAYMENT FOR TREATMENT RECEIVED.

Patient Initials _____BY SIGNING I ATTEST THAT I HAVE READ, UNDERSTAND AND AGREE TO ALL THE ABOVE.

Patient Signature: _____ Date: _____Witness: _____

Authorized representative for the patient requesting treatment, who is unable to sign on his/her own behalf.
By: _____ Legal Relationship: _____
Explanation:
_____

OPTIMAL INSTRUMENT DIFFICULTY – BASELINE

Instructions: Please circle the level of difficulty you have for each activity today	Able to do without any difficulty	Able to do with little difficulty	Able to do with moderate difficulty	Able to do with much difficulty	Unable to do	Not applicable
1. Lying Flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving- lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/Stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Standing	1	2	3	4	5	9
10. Walking- short distance	1	2	3	4	5	9
11. Walking- long distance	1	2	3	4	5	9
12. Walking- outdoors	1	2	3	4	5	9
13. Climbing stairs	1	2	3	4	5	9
14. Hopping	1	2	3	4	5	9
15. Jumping	1	2	3	4	5	9
16. Running	1	2	3	4	5	9
17. Pushing	1	2	3	4	5	9
18. Pulling	1	2	3	4	5	9
19. Reaching	1	2	3	4	5	9
20. Grasping	1	2	3	4	5	9
21. Lifting	1	2	3	4	5	9
22. Carrying	1	2	3	4	5	9

23. From the above list, choose the 3 activities you would most like to be able to do without any difficulty (for example, if you would most like to be able to climb stairs, kneel, and hop without any difficulty, you would choose 1. 12, 2. 8, 3. 13)

1.____2._____3. _____

24. From the above list of three activities, choose the primary activity you would most like to be able to do without any difficulty (for example, if you would most like to be able to climb stairs without any difficulty, youwould choose: Primary goal. 12)

Primary goal _____