



Physiotherapy WORKS L.L.C

Winter Park

1860 State Rd 436, Suite 1000

Winter Park, FL, 32792

T (407) 657 5029

F (407) 657 6320

Waterford Lakes

12301 Lake Underhill Rd, Suite 118

Orlando, FL, 32828

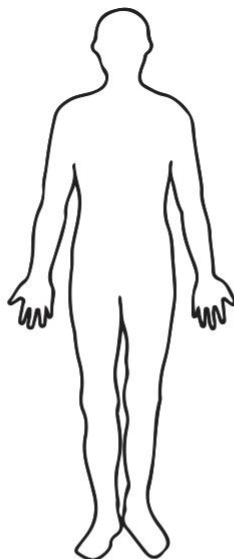
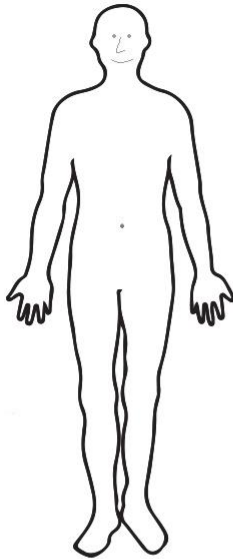
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INTENSITY OF YOUR PAIN - IN THE LAST 2 WEEKS

FRONT

BACK



PLEASE SELECT THE WORDS THAT BEST DESCRIBE YOUR SYMPTOMS

DULL

ACHING

BURNING

COLD

SHOOTING

STABBING

SHARP

PINCHING

THROBBING

SORENESS

BRUISED

CRAMPING

GRIPPING

SQUEEZING

HEAVINESS

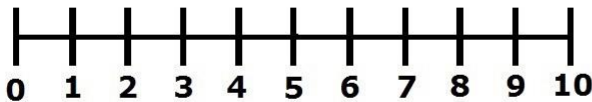
WEAKNESS

NUMBNESS

TINGLING

TIGHT

EMPTY



0
very happy,
no pain



1-2
hurts just
a little bit



3-4
hurts a
little more



5-6
hurts even
more



7-8
hurts a
whole lot



9-10
hurts as much
as possible

CURRENT PAIN ___/10

AT BEST ___/10

AT WORST ___/10

OTHER MEDICAL HISTORY

OTHER MEDICAL PROBLEMS/DIAGNOSES _____

SURGERIES/ACCIDENTS/INJURIES _____



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FUNCTIONAL ACTIVITIES - QUESTIONNAIRE

	0	1	2	3	4
How Much Difficulty do you have with the following activities	No difficulty 0%	Mild difficulty 0-25%	Moderate difficulty 25-50%	Severe difficulty 50-75%	Unable 100%
Sleeping					
Turning over in bed					
Getting out of a chair					
Making you bed					
Washing/dressing					
Making meals					
Feeding yourself					
Housework					
Yard work					
Walking 2 blocks					
Walking 1 mile					
Walking on uneven ground					
Climbing 10 steps					
Travelling in a car/bus					
Getting in or out of car/bus					
Standing 1 hour					
Sitting 1 hour					
Picking up item from floor					
Reaching overhead					
Lifting groceries					
Lifting a laundry basket					
Reading					
Handling own finances					
Performing work duties					
Maintaining social contact					

How many minutes or how far can you walk? _____

How long can you stand for? _____

How long can you sit for? _____

How much weight can you lift from the floor? _____

How much weight can you carry? _____

Are you R or L handed

[] R [] L

WHAT ARE YOUR GOALS FROM PHYSICAL THERAPY

1. _____
2. _____
3. _____



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HOME HEALTH

HAVE YOU RECENTLY OR ARE YOU NOW RECEIVING HOME HEALTH CARE FOR ANY OF THE FOLLOWING

- PHYSICAL THERAPY OCCUPATIONAL THERAPY SPEECH THERAPY
 IV THERAPY INJECTIONS OR MEDICATIONS BATHING OR PERSONAL CARE

BILLING POLICY

PHYSIOTHERAPY WORKS, LLC WILL BILL YOUR INSURANCE FOR TREATMENT SHOULD YOU HAVE COVERAGE. OTHERWISE WE SHALL ACCEPT \$65 PER HOUR FOR MASSAGE THERAPY OR \$85 FOR EACH PHYSICAL THERAPY SESSION WHEN PAID AT THE TIME OF SERVICE.

INITIALS

CANCELLATION POLICY

I UNDERSTAND THAT MY APPOINTMENT TIMES ARE BEING RESERVED ESPECIALLY FOR ME. AS A COURTESY TO MY THERAPISTS AND OTHER PATIENTS, IF I AM UNABLE TO MAKE THE APPOINTMENTS AT THE TIMES THAT I HAVE SCHEDULED **I WILL GIVE AT LEAST 12 HOURS NOTICE OR I WILL BE CHARGED \$35 LATE CANCELLATION/NO SHOW FEE.** I ALSO UNDERSTAND THAT THIS CHARGE CANNOT BE BILLED TO MY INSURANCE.

INITIALS

CONSENT FOR TREATMENT

I GIVE MY CONSENT TO THE PROVISION OF EXAMINATION, TREATMENTS, THERAPIES, AND SUPPLIES AS ORDERED BY THE THERAPIST AT PHYSIOTHERAPY WORKS, LLC. I AKNOWLEDGE THAT NO GUARANTEE OR ASSURANCE HAS BEEN MADE AS TO THE OUTCOME OF SUCH TREATMENTS, PROCEDURES AND EXAMINATIONS.

PRIVACY POLICY

I HAVE BEEN ISSUED WITH A NOTICE OF PRIVACY PRACTICES (HIPAA NOTICE).

INITIALS

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

PRINTED NAME _____

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS FORM COMPLETELY.



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ACKNOWLEDGMENT OF LIABILITY ASSIGNMENT OF BENEFITS

The undersigned patient and/or responsible party, hereby acknowledge personal responsibility and liability for all the medical services, which are provided by **Eric Mason PT/Physiotherapy Works, LLC**. This personal obligation is not affected by any obligation of insurance companies to pay health care costs. If an insurance company pays the payments shall be credited to your account. If no insurance payment is received, you may be completely responsible to pay for all medical treatments. In addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered, the undersigned hereby assigns to the physician or facility named above the following rights, power, and authority:

CONSENT FOR TREATMENT: The undersigned hereby consents to the provision of examination, treatments, therapies, and supplies to the patient as ordered by the patient’s health care provider **Eric Mason PT/Physiotherapy Works, LLC**, their physical therapists, physical therapy assistants, massage therapists or staff, and acknowledges that no guarantee or assurance has been made to the results of such treatments, procedures or examinations.

RELEASED INFORMATION: You are authorized to release and to permit the examination or copying of any of my medical records, x-rays, laboratory reports, and the results of all tests of any type or character to such person(s) as the Physician and/or facility deems appropriate.

ASSIGNMENT OF RIGHTS: You are assigned to exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company or other person or entity to the extent of your bill for total services, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payments, and prosecute and receive penalties, interest, court costs or other legally compensable amounts owed by an insurance company or other person of entity. I, as the patient and/or responsible party, further agree to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request. The physician and/or facility is also assigned the exclusive, irrevocable right to request and receive from any insurance company or health care plan any and all information and documents pertaining to my policies including a copy of such policy and my information or supporting documentation concerning or touching upon the handling, calculation, processing, or payment of any claim. The physician and/or facility is also assigned the right to request and receive a list of all payments made under any coverage, as well as a list of what bills were received, and when they were received.

DEMAND FOR PAYMENT: As to any insurance company providing benefits of any kind to me/us for treatment rendered by the therapist/facility named above you are hereby tendered the right to demand payment in full the bill for services rendered by the therapist/facility named above following your receipt of such bill for services to the extent such bills are payable under the terms of my/our policy for benefits, less any amounts which I/we owe personally which are not payable under the terms of your policy.

THIRD PARTY LIABILITY: If patient(s) treatments for injuries are the result of the negligence of any third party, then patient(s) grant a secured interest (lien) against any recovery from such third party(s) to the extent of the bills for treatment in favor of the physician/facility named above.

In the event that any provision of this Agreement is determined to be invalid or unenforceable, all other provisions of this Agreement shall remain enforceable.

A PHOTOCOPY OF THIS INSTRUMENT SHALL SERVE AS ORIGINAL

Signature of patient and/or responsible party:

Sign Here _____

Date: _____

Print Name Signature _____

Relationship: _____

PATIENT’S NAME: _____

Date of Accident: _____



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ABOUT YOUR INSURANCE

It is extremely important that you understand your insurance coverage.

Please take the time to call the customer service number on the back of your insurance card.

Please inform the representative that you will be attending therapy at PHYSIOTHERAPY WORKS, LLC.

You might want to ask the following questions:

- 1) Do you need to have an authorization your therapy? _____
If authorization is needed please call the referring doctors office referral coordinator and ask them to obtain an authorization for you.
- 2) Do you have a co-pay? _____
- 3) Do you have a deductible? _____
- 4) Are you responsible for a portion of the bill? _____
- 5) Do you have a visit limit _____
- 6) What is the benefit period from _____ to _____.
- 7) Is PHYSIOTHERAPY WORKS, LLC or ERIC MASON, PT in network or out of network.
- 8) If you have Medicare, have you used any of this years Medicare allowance for outpatient therapy? _____ If so how much? _____.

It is the patient's responsibility to know that insurance coverage. Your insurance company will be billed and you may be responsible for any balance not covered by your insurance

Notice of Privacy Practices for Physiotherapy Works, LLC (HIPAA Notice)

Effective Date: April 14,2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. REVIEW IT CAREFULLY.

Your Health Information Rights

Although your health record is the physical property of the healthcare organization that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information
- obtain a paper copy of the notice of information practices upon request
- inspect and obtain a copy of your health record
- amend your health record
- obtain an accounting of disclosures of your health information
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

This organization is required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction

- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice.

Examples of Disclosures for Treatment, Payment and Health Operations:

We will use your health information for treatment purposes.

For example: Information obtained by a physical therapist, acupuncturist, chiropractor, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. The physical therapist will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physical therapist will know how you are responding to treatment.

We will also provide a subsequent healthcare provider with copies of various reports that should assist him or her in treating you.

We will use your health information for payment purposes.

For example: A bill may be sent to you or a third-party payer such as

an insurance company, the Medicare program or any other organization, person or program that may be responsible for paying for services. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

For example: Health care providers within the organization, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: There are some services provided in our organization through contracts with business associates. An example is a laboratory which performs certain laboratory tests or a nurse or physician who is an independent contractor. There may be additional independent contractors. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative,

or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgement, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you or otherwise provide information about additional services or health care products you may find useful.

Fund raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers' compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Legal Matters: In the event of a claim, litigation or other legal proceeding or contemplated legal matter, we may disclose health information to our attorneys and individuals or organizations working for them.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact Eric Mason, the HIPAA Privacy Official, at the Physiotherapy Works. LLC, 1890 Semoran Blvd. Suite 251. Winter Park, PL 32792 or (407) 657 5029.

If you believe your privacy rights have been violated, you can file a complaint with the HIPAA Privacy Official for Physiotherapy Works, LLC or with the secretary of Health and Human Services.

There will be no retaliation for filing a complaint.

Other Uses of Protected Health Information

Other uses and disclosures of protected health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose protected health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.