Appt Reminder:
☐ Text
☐ Call

PHYSICAL/OCCUPATIONAL/SPEECH
AESTHETIC SURGICAL MANAGEMENT

REFERRED BY: _____

ARE YOU A FORMER PATIENT OF ASPEN REHAB: YES NO FIRST VISIT: _____

DIAGNOSIS/CHIEF COMPLAINT: _____

WAS THIS A RESULT OF AN **AUTO ACCIDENT** OR **INJURY AT WORK**: YES NO

HAVE YOU RECEIVED THERAPY AT ANOTHER FACILITY THIS YEAR: YES NO

IF YES, WHERE? _____

PATIENT NAME: _____ SOCIAL SEC#: _____

CAREGIVER: _____ RELATIONSHIP: _____ PHONE: _____

ADDRESS: _____ CITY: _____STATE:_____

ZIP CODE: _____ HOME #: _____WORK/CELL #: _____

D.O.B:_____ E-MAIL:_____

EMPLOYER: _____ PH#:_____

REFERRING PHYSICIAN: _____ OFFICE #:_____

EMERGENCY NAME/NUMBER: _____

AUTO ACCIDENT

Date of Accident: _____ Attorney Name: _____ Phone Number: _____

Adjuster Name: _____ Adjuster Phone Number #: _____

AUTO Insurance Company Name: _____ Phone #: _____

Policy Number #: _____

WORKERS COMPENSATION

Adjuster Name: _____ Phone Number #: _____

Workers Comp Company Name: _____ Phone Number #: _____

Case #: _____

STAFF ONLY: CASE CREATION DATE: _____ CASE CREATED BY: _____

Patient Name: _____

Patient History Questionnaire

Is your current condition related to previous Auto or Workmen's Compensation Injury:
Yes ___ No____

Date of your injury/surgery: _____N/A ☐ How did it occur?_____

Onset date of your disorder/pain: _____N/A ☐ Have you had this problem before? Yes ☐ No ☐

If yes, when? _____ What did the treatment consist of: _____

Patient's past medical history: Please check all that apply to you.

Diabetes	☐	Pacemaker/ implantable defibrillator?	☐
Cancer	☐	Hypertension/High Blood Pressure	☐
Heart Disease/Angina	☐	Shortness of Breath/ Asthma	☐
Allergies (Medication)	☐	Stroke	☐
Are you allergic to Latex?	☐	Osteoporosis	☐
Balance Disorders	☐	If applicable, are you pregnant?	☐

Other:_____

What are your goals in coming to physical therapy? _____

_____

How are you limited in your day to day activities? _____

_____

Cultural/Religious- Any customs or religious beliefs or wishes that might affect care? _____

_____

Occupation: _____

Job involves: Prolonged sitting ☐ Prolonged standing/walking ☐ Lifting/climbing/reaching etc… ☐

Do you exercise regularly? Yes ☐ No ☐ If yes, how often? _____ How long?

_____

What type of exercise do you do?_____

Do you have difficulty sleeping because of your problem? Yes ☐ No ☐

If yes, number of times you wake up: _____ What position do you sleep in:_____

How do you best learn? ☐ Pictures ☐ Reading ☐ Listening ☐ Demonstration

☐ Other _____

Patient Name: _____

Have you had any x-rays, MRI, or other diagnostic tests performed? Yes ☐ No ☐
If yes, what are the results of the tests:

_____

Please list any surgery you have had and the date(s) of that surgery below:

_____ _____
_____ _____
_____ _____

PAIN BEHAVIOR: Please **CHECK** any items below that apply to you.

Aching ☐	Throbbing ☐	Sharp ☐	Dull ☐
Nagging ☐	Constant ☐	On/Off ☐	

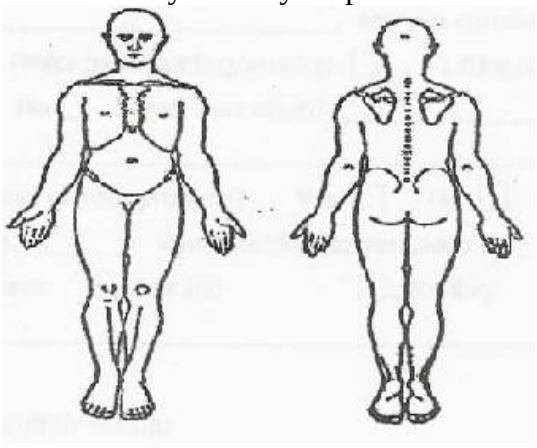
Your pain is worse: Please **CHECK** any items below that apply to you.

Bending ☐	Sitting/rising ☐	Standing ☐	Walking ☐	Lying ☐
In AM ☐	As day progresses ☐	In PM ☐	At rest ☐	On the move ☐

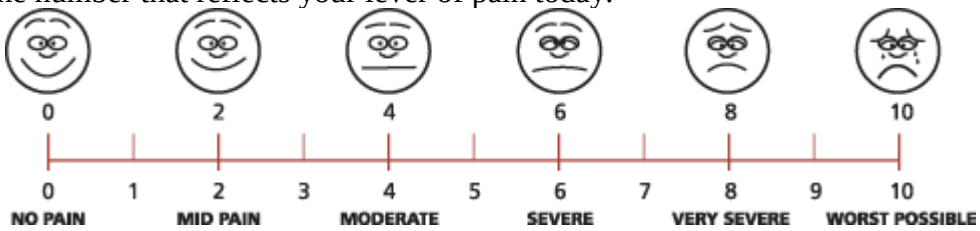
Your pain is better: Please **CHECK** any items below that apply to you.

Bending ☐	Sitting/rising ☐	Standing ☐	Walking ☐	Lying ☐
In AM ☐	As day progresses ☐	In PM ☐	At rest ☐	On the move ☐

Mark on the drawing below the areas where you feel your pain.



Please circle the number that reflects your lever of pain today.



Aspen Rehab
GO AHEAD. GET BETTER

MEDICATION SHEET
PLEASE LIST ALL YOUR CURRENT MEDICATIONS,
THE DOSAGE, HOW MANY TIMES A DAY YOU TAKE THEM,
HOW YOU TAKE THEM (TABLETS OR INJECTABLE)

Patient Name : _____ Date: _____

Name of Medication	Dosage	Per Day	Tablets or Injectable

AUTHORIZATION AND CONSENT FOR TREATMENT

1. I, the undersigned, acting on my behalf or as the legally authorized representative of patient stated below, do consent for treatment provided by SMART HEALTH SOLUTIONS, P.A. doing business as **Aspen Rehabilitation**. I agree to treatment by its employees, independent contractors, and business associates, which relate to care and treatment as designated. .

2. I understand and acknowledge that I am fully responsible for payment and any charges for care and services provided by Aspen Rehabilitation. If I am entitled to benefits or insurance of any kind from any policy of insurance, including, but not limited to: Medicare, Personal Injury Protection (PIP), or other auto and liability insurance covering me, or any party liable to me, I authorize payment of these benefits directly to Aspen Rehabilitation. I further understand and acknowledge that Aspen Rehabilitation will bill me for any co-payment and/or balance after my insurance carrier has paid or denied my claim, and will be responsible for any balance not paid. I further understand that Aspen Rehabilitation may send any outstanding unpaid balances to a collection agency and/or collections attorney to recover funds unpaid and that the cost of collections and/or legal fees will be included in the outstanding balance owed.
_____***(initials)***

Co-pay due each visit $_____ Co-Insurance due per visit _____%
Deductible Amount $_____ Other negotiated pay per visit $_____
As calculated by your insurance company at the time of you 1st visit. This may vary per your insurance calculations.

3. I understand that Aspen Rehabilitation may share my medical information, without my consent or express authorization, to my physician, providers, payers, business associates, and other entities for the purpose of treatment, payment, or healthcare services. My signature below authorizes this sharing of my information and that no information will be shared, used, disseminated, and collected for any other purposes than previously described.

4. I understand that Aspen Rehabilitation will provide therapy services that with diagnosis and treatment may involve risk and injury. I acknowledge that no guarantees have been made to me as a result of examination, care, or treatment. I acknowledge that I have the right to request an explanation of risks and benefits from services provided.

5. I understand that Aspen Rehabilitation is not legally responsible for the acts and omissions of its independent contractors.

6. I understand that Aspen Rehabilitation's **Cancellation Policy requires 24 hours notice or a $40 charge** may be imposed. This also applies when I arrive at least 15 minutes late to an appointment. I also understand that not showing for appointments without cancellation on two (2) or more occasions may result in being discharged from therapy services. _____ ***(initial)***

7. I understand that if I receive any insurance payments directly from my insurance carrier for services performed, I will immediately (no later than 5 days) pay over such payments to Aspen Rehabilitation. _____ ***(initial)***

8. I hereby acknowledge that I have received a copy of Aspen Rehabilitation's NOTICE OF PRIVACY PRACTICES for my review, prior to receiving initial services from Aspen Rehabilitation, either now or in the past.

*****Speech Therapy Patients: If you have any questions regarding billing or need to make a payment, please call (954)341-7875 and ask to speak with our billing department. *****

SIGNED: **DATE**:

_____ _____

(Patient or person legally authorized to consent for patient)

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PHYSICAL/OCCUPATIONAL/SPEECH
AESTHETIC SURICAL MANAGEMENT
9900 W. Sample Rd., Suite 102
Coral Springs, FL 33065
Office: (954) 341-7875
Fax: (954) 341-7895

Authorization to Release Medical Information/HIPPA Compliance

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

I authorize the release/request of my protected health information to/from:

□ Physician: _____

□ Family Member: _____ Relationship to Patient: _____

□ Diagnostic Testing Center: _____

□ Other: _____

My information may be released in the form of: □ Paper Copy □ Electronic Copy

The purpose for this request to release medical information is:

□ Medical Care / Treatment □ Insurance □ Other (Specify): _____

I understand that:

- By signing this form, I am authorizing the use or disclosure of protected health information as indicated above.
- I may refuse to sign this authorization, which will not affect my treatment or payment for healthcare.
- I may revoke this authorization at any time before the information I have requested is released by providing written notice of revocation as specified in the Notice of Privacy Practices.
- If the receiving party is not subject to medical records privacy laws, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law. Aspen Rehabilitation shall not be held liable for any consequences resulting from re-disclosure.
- If the information to be release contains any information about HIV/AIDS and additional HIPPAA release of medical Information for will be requested.
- Alcohol or substance abuse, mental health or psychiatry notes may have additional compliance requirements that must be met before the information can be released
- A copy of this signed form may be provided to me if I request it.
- Aspen Rehabilitation may charge and administrative fee to cover cost of labor, copying, and postage for any and all medical records. The physician's office will inform me of any charges and arrange for payment.
- This Authorization Expires on _____/____/____ (if date not completed/ one year after signed)

Patient/ Representative Signature _____ Date: _____