"Limp In Leap Out"
Lilo Physiotherapy Inc.

PATIENT INFROMATION:

PERSONAL

Patient Name: _____
Address: _____
City, State, and Zip Code: _____
Date of Birth: _____Age: _____Sex: _____ Home#: _____Cell#_____
Email: _____
Out State Address: _____
_____
Emergency Contact: _____Phone#: _____
How did you hear about us: _____

CURRENT CONDITION

Date of injury: _____ Mechanism of injury: _____
Describe your chief complaint / concern: _____
_____
If you have pain, please circle the intensity (10 being the worst) 0 1 2 3 4 5 6 7 8 9 10

Identify any position / activity that eases your symptoms: _____
_____
Identify any position / activity that aggravates your symptoms: _____
_____
What is your goal with Physical Therapy: _____
_____

PAST MEDICAL HISTORY DIAGNOSIS / SURGERIES

Please list any medical condition you have been diagnosed with or hospitalized for and any metal implants.

_____
_____
_____
_____
_____
_____
_____
_____

PATIENT SIGNATURE: _____Date:_____

Physical Therapist Use Only:

Weight: _____ Height: _____
_____
_____
_____
_____
_____
_____
_____

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MEDICATION LIST

Please list all medications you are currently taking: Prescription and over-the-counter.

PATIENT NAME: _____

MEDICATION	DOSAGE	FREQUENCY	ROUTE OF ADMINISTRATION. (Ex Oral/Inj.)	REASON FOR TAKING MEDICATION

PATIENT SIGNATURE: _____ DATE: _____

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PATIENT CONSENT FORM:

I hereby indicate my wish to be a participant in the rehabilitation program offered by **Lilo Physiotherapy Inc.**

I understand that the purpose of this program is to enhance my recovery from an injury or illness. I further understand that there exists the possibility that certain changes may occur during my treatment.

I understand that I will be informed during my evaluation of the procedures and methods of the treatment that will be administered to me.

I verify that my participation is fully voluntary, no coercion of any sort has been used to obtain my participation, and I may withdraw from treatment at any time.

I understand that the facility administrator maintains an open door policy and encourages patients to participate for any reason.

PATIENT NAME: _____

PATIENT SIGNATURE: _____ DATE: _____

Insurance Assignment Form and / or Medicare Approved Comprehensive Outpatient Rehabilitation Facility:

Insurance authorization and - or Medicare Authorization / Patient release and authorization

- I hereby authorize payment directly to **Lilo Physiotherapy Inc** for the benefits due to me in my pending claim and / or Major Medical Benefits otherwise payable to me, but not to exceed the physician and / or the Corporation's regular charge for therapy for this treatment period.

- I further authorize the release of any medical information required by the insurance carrier(s).

- I verify that the information given by me in applying for payment under title XVIII of the Social Security Act is covered.

- I authorize any holder of medical or other information about me to release to the Social Security Administration or it's intermediaries or carries any information to be used in place of the original and release payment of medical insurance benefits either to myself or the party who accepts assignment.

PATIENT NAME: _____

PATIENT SIGNATURE: _____ DATE: _____

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MEDICAL RELEASE:

1. _____ **I authorize my records to be release to**:

Lilo Physiotherapy
7601 N. Federal Hwy
Suite 220, Bldg A
Boca Raton, FL 33487
Phone # 561-998-0077 / Fax # 561-998-0078

2. _____ **I authorize my records to be released from**:

Doctor Name: _____ Phone#: _____

Address: _____

Records being request: _____

Specific dates of records: _____

3. _____ **Permission to give medical information to**:

(Family member/ friend) Please list names and relation.

_____
_____
_____
_____

PATIENT NAME: _____

PATIENT SIGNATURE: _____ **DATE**: _____

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HIPPA NOTICE OF PRIVACY PRACTICES:

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

This notice of privacy practices described how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to physician to whom you have been referred to ensure that the physician has the necessary information to diagnosis to treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, and training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: As required by law, Public health issues are required by law, Communicable disease: Health Oversight: Abuse or Neglect: Food and Drug administration requirement: Legal proceeding: Law enforcement: Coroners, Funeral directors, and Organ donation: Research: Criminal activity: Military activity and National security: Worker's Compensation: Inmates: Required uses and Disclosures: Required uses and disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and discloser will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent to that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your right with respect to your protected health information.

You have the right to inspect and copy your protected health information: Under federal law, however, you ma not inspect or copy the following records; psychotherapy notes; information compliance in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subjected to the law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information: This mean you may ask us not to use or discloser any part of protected heath information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purpose as described in this Notice of Privacy practice. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and discloser of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice form us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information.

If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosure we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to secretary of health and human services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contract of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14/2003

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protect health information. If you have any objective to this form, please ask to speak with our HIPPA Compliance Office in person or by phone at our Main Phone Numbers.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

PATIENT NAME: _____

PATIENT SIGNATURE: _____ **DATE**: _____

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Cancelation Policy Agreement!

We request that if you must
CANCEL
your appointment that we receive
24-Hour Notice!
Or a charge of $50.00 will
be incurred.

This charge of $50.00 will NOT be billed to your
Insurance carrier, this charge will be your responsibility to pay.
This policy serves as a courtesy to
other patients that are waiting to be seen.

This signed agreement by you the patient shows your responsibility for payment to Lilo Physiotherapy. A bill will be sent to you and if you fail to respond and/or a full payment is not paid by the due date Lilo Physiotherapy has the right to take action.

■ If you fail to respond and/or pay the full balance by the second attempted bill sent to you by the due date actions are as followed:

1) Each WEEK that this bill is not paid in full a charge of $2.50 will be added to your bill.

2) Each bill will only be sent to you monthly and if not paid before the month's end with the current balance a total of $10.00 a month will be added to your new balance.

3) To avoid this reoccurring action and protect your credit from our collection agency, please remit full balance immediately. Once we submit you to collections Lilo Physiotherapy will no longer be able to assist you directly in resolving this situation and/or the outcome.

   Should you have any questions regarding this matter, please contact our office.
   Thank you.

PATIENT NAME: _____

PATIENT SIGNATURE: _____ DATE: _____