CAPE Physical Therapy, LLC

PHYSICAL THERAPY

Patient Name: _____

DOB: _____ **Sex: M / F**

Insurance Name: _____ **ID #:** _____

SSN: _____ **Group #:** _____

Primary Person Insured: _____

Please provide copy of insurance card & Driver's License

Primary phone (H / C / W): _____

Secondary phone (H / C / W): _____

E-mail: _____

Address: _____

City, State, Zip code: _____

Emergency Contact Name/ Relation: _____

Emergency Contact Phone: _____

Referring Physician: _____

phone: _____ fax: _____

Primary Physician: _____

phone: _____ fax: _____

Employer Name: _____

phone: _____ fax: _____

Employer Address: _____

18400 NW 75th Place #120, Hialeah, FL 33015
Phone: 786-656-0691 Fax: 844-770-8268 info@capept.com
Visit us online at www.CAPEPhysicalTherapy.com

CAPE Physical Therapy, LLC

PHYSICAL THERAPY

RELEASE OF LIABILITY & INFORMATION

(initial on each item below)

1._____ **I understand that information of medical, family and other personal history is kept confidential and have received a 'Notice of Privacy Practices' packet**

2. _____ **I authorize COMPANY, LLC to bill my insurance for reimbursement of therapy services and understand that I am responsible for the remaining balance of any unpaid claims if the services are not covered by the insurance carrier**

3. _____ **I have been fully informed of, consent to, and authorize the performance of all appropriate procedures and courses of treatment in the judgment of the licensed therapist**

4. _____ **I understand that the licensed therapist may utilize and direct other medical professionals, assistants, trainees, or therapy students regarding treatment and I accept and consent to this practice**

5. _____ **I have been fully informed of and understand that all healthcare involves risks and side effects, and I accept and consent to any and all reasonable and commonly-occurring risks of occupational & physical**

6. _____ **I acknowledge that no guarantees have been made as to the results of any therapies, and results may vary**

7. _____ **I give permission for COMPANY, LLC to obtain emergency medical treatment, if deemed**

8. _____ **I understand and consent that the determination of whether, when and how to provide OT and PT services is a professional healthcare decision of the licensed therapist, and the licensed therapist may decline treatment and/or discharge from treatment if the licensed therapist determines there is a lack of medical necessity for occupational & physical therapies.**

9. _____ **No shows or last minute cancellations (less than 24 hrs) NOT related to medical emergency will result in a $25 fee to be paid BEFORE you can be seen for your next visit.**

I have read ALL NINE statements listed above and understand their implications as indicated by my initials next to them and my signature below.

_____	_____	_____
Print Patient Name	**Patient Signature**	**Date**

18400 NW 75th Place #120, Hialeah, FL 33015
Phone: 786-656-0691 Fax: 844-770-8268 info@capept.com
Visit us online at www.CAPEPhysicalTherapy.com

Reason for Therapy:	**Date of Injury:**
Is the Reason for Therapy Accident Related? ☐No ☐Yes If yes, please check one: ☐Accident ☐Auto ☐Work ☐Other If other, please explain:	
Are you **currently** receiving any other care for the condition mentioned above?☐ No ☐Yes If yes, please list:	
Have you ever received therapy **in the past** for the condition mentioned above? ☐No ☐Yes	If so, when?

Previous Treatment Received:		Previous Treatment: ☐Successful ☐Unsuccessful

Have you received therapy services for **other problems/conditions during this calendar year**? ☐No ☐Yes If yes, please list:
Could you be or are you pregnant? ☐No ☐Yes
Do you now have or have you ever had any of the following conditions?

Conditions	Yes	No
Arthritis	☐	☐
Osteoporosis	☐	☐
High Blood Pressure	☐	☐
Heart Disease/Heart Attack	☐	☐
Pacemaker	☐	☐
Stroke	☐	☐
Vascular Disease	☐	☐
Hypersensitivity to Heat/Cold	☐	☐
Asthma	☐	☐
Shortness of Breath	☐	☐
Chronic Cough	☐	☐
Dizziness/Light Headedness/Fainting	☐	☐
Nausea/Vomiting	☐	☐

Conditions	Yes	No
Diabetes	☐	☐
Anemia	☐	☐
Swelling in Ankles	☐	☐
Deep Vein Thrombosis (DVT)	☐	☐
Seizures / Epilepsy	☐	☐
Fatigue / Weakness	☐	☐
Cancer / Tumor	☐	☐
Recent Weight Loss or Gain	☐	☐
HIV / AIDS	☐	☐
Hepatitis	☐	☐
Tuberculosis	☐	☐
Recurrent Infection(s) or Infection in past 3 months	☐	☐
Fever / Chills	☐	☐

Conditions	Yes	No
Numbness / Tingling	☐	☐
Thyroid Problems	☐	☐
Headaches	☐	☐
Head Injury / Concussion	☐	☐
Hernia	☐	☐
Kidney / Bladder Problems	☐	☐
Previous Fractures	☐	☐
Previous Surgeries	☐	☐
Metal in Body or Surgical Implants	☐	☐
Depression	☐	☐
Anxiety	☐	☐
Smoking	☐	☐
Other (please describe below)	☐	☐

If you answered "*yes*" on any of the above or have other conditions not listed, please explain and give approximate date(s):
Do you have any allergies? ☐No ☐Yes, list allergies:
Are you presently taking any medications? ☐No ☐Yes, list medications and specify condition:
At the present time, would you say that your health is (circle one): Excellent Very Good Fair Poor
The information is correct to the best of my knowledge.

X	
Patient/Parent/Guardian Signature	Date

CAPE Physical Therapy, LLC

PHYSICAL THERAPY

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name:	Date of Birth:
Address:	Phone:

Copies of Medical Records:

☐Most recent therapy prescription
☐Operative Record
☐X-Ray and Imaging Report
☐History & Physical
☐Discharge Summary
☐Lab reports
☐Immunization Record
☐Emergency Room Record
☐Clinic Notes [date(s)] and Doctor's Name:

_____

_____

☐Other:

_____

_____

Verbal Disclosure of Information:

I understand that I am giving my permission to release information in my medical record that may include information relating to my condition and/or injury.

_____ _____ _____

Patient name Patient Signature Date

INFORMATION RELEASE TO:
CAPE Physical Therapy , LLC.
18400 NW 75th Pl #120
Hialeah, FL 33015

Purpose of Disclosure:

☐Continuing Care
☐Personal
☐Insurance
☐Legal

18400 NW 75th Place #120, Hialeah, FL 33015
Phone: 786-656-0691 Fax: 844-770-8268 info@capept.com
Visit us online at www.CAPEPhysicalTherapy.com