ON THE HOP ORTHO, SPORTS & AQUATIC THERAPY
7171 N. University Drive, Suite # 111 Tamarac, FL
Phone: (954) 722-9992 Fax: (954) 597-7773

Welcome To Our Office!

Patient Name: _____ Nickname/preferred name (if any):_____

Date of Birth: _____ Age:_____ Height:_____ Weight:_____

Home Address:_____

Secondary Address (if any):_____

Home Phone #:_____ Mobile/Cell Phone#:_____

Email Address:_____

Social History: (circle all that apply)

*Single *Married *Divorced *Widowed *Lives Alone *Lives w/other *Independent living facility *Assisted living

*Unemployed *Employed *Retired _____Current /former Occupation

Hobbies/activities:_____

Exercise: type(s):_____ frequency:_____

Do you have stairs at home/work? _____

Do you have a walk-in shower? _____ Bath tub?_____ Do you have safety bars?_____

Patient Signature:_____ Patient Printed Name:_____ Date:_____

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Patient Name:_____ Referring MD:_____

Chief Complaint:_____

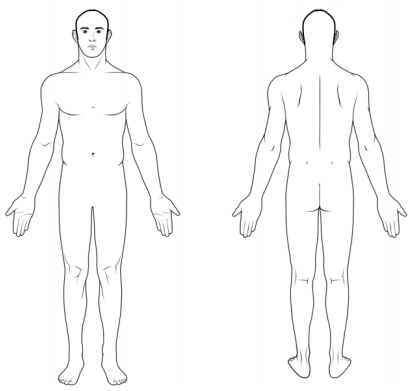
Why are you being seen today?_____

Type of Injury: ___None ____sports ___slip and fall ___auto accident ___work related accident ___other(explain)

How long have you had this problem:_____ When did it become severe:_____

Location of pain:

Right Left Left Right



Description of pain: ___Occasionally ___Constant ___Daily ___

___worse w/motion ___wakes from sleep ___ worse in morning ___night

___sharp pain ___dull ache ___throbbing ___burning ___stabbing

___radiating pain ___vague

Rate your pain level: 0 (no pain) – 10 (worst pain imaginable) :

Current: ____/10 at rest: ____/10 at worse: _____/10

Functional Limitations:

Difficulty: ___sitting ___rising from sitting ___standing ___walking ___ sleeping on side ___ raising arm

___putting on shoes/socks ___ light – moderate lifting ___personal hygiene ___climbing stairs ___negotiating curbs

___getting in/out of car or bed ___performing usual physical activities (be specific; ie golf, gardening, knitting etc…)

Do you use a cane or walker? _____ If so, for how long?_____

Has your leg given out? Or have you fallen?_____ If yes, when? _____ Did you need assistance to get up? ____

Did fall(s) require medical attention, surgery or hospitalization? _____ Can you walk more than one block?_____

Does the pain/disability limit your ability to perform your activities of daily living? _____

Patient Signature:_____ Date: _____

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Patient Name:_____

Past Medical History: (circle all that apply) *None

*Asthma *Sleep Apnea *Blood Clot * High Blood Pressure *Diabetes *Lung Disease –COPD *Ulcers *Diverticulitis

*Heart Disease *Stroke *Hepatitis *Nerve Disease/Neuropathy *Kidney disease * Gout *HIV/AIDS

*Arthritis *Rheumatoid Arthritis *Fibromyalgia *Osteoporosis *Osteopenia * Fractures :_____

*Cancer (type)_____ Other:_____

Past Surgical History: (circle all that apply) *None

*Appendectomy *Gall Bladder *Hernia *Stomach/Colon *Cataracts *Heart Bypass/Stents *Pacemaker

*Neck/Back *Shoulder/hand * Hip *Knee *Ankle/foot *Joint Replacement (Location):_____

General Review : Check/ Circle all that apply

*Fever *Chills *Weight Loss *Weight Gain *Nausea *Dizziness * Visual Impairment *Hearing Loss *Vertigo

*Shortness of Breath *Anxiety *Depression *Fatigue *Insomnia *Headaches *Memory loss * Incontinence

*Swelling *Bleeding *Numbness/tingling *Skin Lesions/Rash *frequent falls *Allergies:_____

*Other_____

Please list current medications/dosage:

_____
_____
_____
_____

Patient Signature:_____ Date:_____

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FORMS, LETTERS AND MEDICAL RECORDS FEES

The following are office charges for processing requests for form completion, letters and copies of medical records.

Payment is due prior to services being rendered.

$25.00 charge for :

Disability Insurance forms

Sickness/Accident Insurance forms

FMLA forms

Medical Records

$1.00 per page for the first 25 pages

$0.25 for ea additional page

Initials _____

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INSURANCE AND PAYMENT POLICIES

YOU ARE RESPONSIBLE FOR YOUR INSURANCE POLICY

Your insurance policy is a contract between you and your insurance company and its terms define your rights and responsibilities. Due to the hundreds of policies available and the many changes in insurance plans, we cannot be responsible for knowing and interpreting each individual policy. It is your responsibility to know your coverage, its limitations and whether or not the medical services/provider is a participant for your specific plan. We urge you to check with your insurance company regarding your benefits. Failure to do so could result in you or the financially responsible party being responsible for all costs incurred in treatment.

NON-PARTICIPATING PROVIDER POLICY

If On the Hop Therapy is not a participating provider for your insurance plan and you choose to be treated here, we will collect fees in full at the time of service.

YOUR FINANCIAL RESPONSIBILITY

You are responsible for payment of any co-payments, co-insurance, deductibles, etc. at time of service as specified by the terms of your insurance plan.

Our office will file insurance claims for all reimbursable services to both your primary and secondary carriers. All deductibles and co-pays are collected at the time of service. Any other amounts due will be billed monthly. If your account becomes delinquent, it may be referred to a collection agency and you will be assessed a 35% agency fee and any costs of litigation incurred in collecting your delinquent account. Checks returned with NSF, will be assessed bank charge of $35.

Patient signature:_____ Date:_____

Print patient name:_____

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Policy for "No Show" appointments

We work hard to respect patients' wishes to get appointments as quickly as possible and to make them at times that are most convenient. In order to do this, we in turn, ask patients to be mindful of the fact that there are a limited number of patients our medical providers can see in a day. When someone fails to show for an appointment without notifying us in advance, another patient has lost the opportunity to be seen at that time, and we have lost the ability to render our services to someone in need.

We find that most patients keep their appointments and notify us in advance when they must reschedule or cancel. Should you cancel 24 hours or more in advance from your schedule appointment time, there is no penalty. If you cancel within 24 hours of your scheduled appointment time, you will receive a warning the for the first instance. You will be charged $25 for the second occurrence, and charges will increase in $25 increments for every occurrence thereinafter if the cancellation falls within 24 hours of your appointment.

There are other cases, however, called "no shows"; patients who REPEATEDLY fail to come in for appointments and do not let us know ahead of time they will not be coming. In these cases we have instituted a policy of charging for "no shows". The charge is billed to patients directly as insurance policies do not cover charges of this nature. Because we understand that in life there are sometimes unforeseen circumstances that may prevent a patient from keeping an appointment, the first time a "no show" occurs, we will take note of it, but there will be no charge. If, however, the patient fails to show for additional appointments, a $25.00 charge will be assessed each time. Patient will be responsible for payment before another appointment is made.

Being able to respect your needs for timely and convenient appointments is very important to us and for that reason we provide the courtesy of appointment confirmations by way of calls and/or email messages. Whether or not we are able to speak with patients personally or deliver messages to confirm existing appointments, we expect patients to keep track of appointments made and to keep them, barring urgent and /or unforeseen circumstances. We thank you for understanding the need for us to have a policy of this nature.

Patient name:_____ Date:_____

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PHYSICAL THERAPY CONSENT FOR TREATMENT

I, the undersigned acknowledge that my (or patient's) physician_____ , has prescribed a course of physical therapy in order to help improve my flexibility, strength, function, endurance and I,/or to alleviate pain.

I further acknowledge that the purpose of physical therapy, reasonable alternative forms of care, risks of the recommended and alternative care options , and the risks of no participating in physical therapy have been explained to me (or patient) by the prescribing physician.

I have had the opportunity to discuss the above with the prescribing physician and after consideration hereby consent and agree to the course of physical therapy that has been recommended.

I understand and acknowledge that, whether signing as a patient or authorized agent, I am responsible for payment of any charges incurred for care and services provided by On the Hop Ortho, Sports & Aquatic Therapy (OTH). In the event that I am (or the patient is) entitled to insurance or health benefits of any time whatsoever arising out of any policy of insurance, including, but not limited to, Medicare, Personal Injury Protection (PIP), other auto/or liability insurance covering me (or the patient), or any party liable to me (or the patient), I authorize payment of said benefits directly to OTH and do hereby assign those benefits to OTH.

I further understand that OTH will bill me for any co-insurance and/or balance after my insurance carrier has paid or denied my claim and that am responsible for any balance not paid.

I acknowledge that OTH may disclose my medical information, without my consent or expressed authorization, to other medical providers, payers, business associates or other entities for the purpose of treatment, payment or healthcare operations.

I understand it is necessary for me to immediately report to a staff member any signs or symptoms that indicate an abnormal feeling or the possibility that I may be in physical distress.

I understand that the reaction of my cardiovascular system to various forms of exercise cannot be predicted with complete accuracy, I also understand that there are risks of certain changes to my body which may occur before, during and/or after engaging in physical/aquatic therapy which include, but are not limited to, abnormalities in blood pressure and or heart rate, cardiac arrhythmias, stroke and cardiac arrest, which may result in injury or even death. Additionally, I acknowledge that musculoskeletal injuries may occur with exercise and that they may also occur in the performance of normal daily activities and while at rest.

I understand that it is my responsibility to be dressed appropriately, including but not limited to footwear for both land/aquatic therapy.

I understand that OTH has lockers available for patient use, however, I acknowledge that it bears no responsibility for loss or damage to valuables or personal belongings and I am advised to leave valuables at home during therapy skills.

I have read this document fully and have had the opportunity to discuss the contents with the staff of OTH. I have had any questions answered to my satisfaction and understand the information that has been provided to me.

_____

Signature of patient (or person authorized to consent for patient and relationship to patient)

Witness:_____ Date_____

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ASSUMPTION OF RISK AND GENERAL RELEASE AND HOLD HARMLESS

My physician has advised that I should undergo aqua therapy under the care of a physical therapist as a means of treating my physical condition. I have elected to seek aqua therapy from On The Hop Ortho, Sports + Aquatic Therapy L.L.C., a Florida corporation, located at 7171 North University Drive, Tamarac Florida 33321 (the "Provider"). The Provider has arranged for the use of the swimming pool for which I will receive aqua therapy services under the care of the Provider. The undersigned hererby acknowledges that swimming pools and the surrounding areas of a swimming pool ("the Pool Area") are inherently dangerous due to slippery surfaces and other potentially hazardous conditions which pose a risk of drowning or other injury.

This will confirm that I have chosen to receive aqua therapy at the Pool Area. I acknowledge the existence of potentially hazardous conditions inherent in swimming pools and will take all reasonable actions necessary to assure my safe use of the Pool Area, including the use of appropriate footwear to minimize slipping on wet surfaces surrounding the Pool Area. I will also strictly comply with all posted warnings and instructions at the Pool Area. In consideration for my being allowed to use the Pool Area, I acknowledge that I do so freely and assume for myself all risk of personal injury or property damage that I may suffer, incur or cause. Furthermore, I agree to hold On The Hop, Ortho, Sports + Aquatic Therapy L.L.C., and Berkowitz Holding, L.L.C., and its respective partners, officers, agents and employees free and harmless from and of loss, liability, damage, cost or attorney fees incurred by me or caused by my participation in aqua therapy treatments, or any other use of the Pool Area, including any loss or injury sustained.

Signature:_____ Date:_____

For those persons under the age of eighteen (18) years:

I hereby consent and agree to the above as the Parent/Legal Guardian of the following minor: _____.

In which case "I", "me", "my", and "myself" as used herein shall refer to the foregoing minor.

_____

Parent