T&SC
THERAPY AND SPORTS CENTER

412 12th Avenue North
St. Petersburg, FL 33701
727-898-5001 Phone / 727-894-0554 Fax

DATE: _____

PATIENT NAME: _____ **D.O.B.**_____

AUTO INSURANCE : _____ **D.O.I.**_____

CLAIM #: _____ **POLICY #:** _____

RE: Authorization for Release of Insurance Information

I, _____, authorize the release of information regarding my Auto claim (PIP, Med Pay, Deductible, EMC) as well as any information related to my Auto case, to Therapy & Sports Center.

_____ _____
Patient Date

_____ _____
Therapy & Sports Date

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

PHYSICAL THERAPY EVALUATION AND TREATMENT.

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)* | Signature | Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**)*:

Name *(PRINT or TYPE)* | Signature | Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

THERAPY AND SPORTS CENTER

Auto Insurance Information / PIP Verification Form

Claim Information

Patient Name: _____ D.O.B: _____

Auto Insurance Carrier: _____

Claims Mailing Address: _____

Claim #: _____ Date of Accident: _____

Adjustor's Name: _____

Adjustor's Phone #: _____ Adjustor's Fax#: _____

Attorney Information

Do you have an attorney involved in this case? YES NO
Attorney's Name: _____

Attorney's Address: _____

Attorney's Phone: _____ Attorney's Fax #: _____

May Therapy and Sports Center, Inc., speak to your attorney regarding your case? YES NO

PIP Verification

Did you receive treatment within the first 14 days after your automobile accident? YES NO

If no, please note that none of your personal injury protection (PIP) allowance will be released to cover your medical expenses. (Florida HB: 0119)

If yes, were you diagnosed with an "Emergent Medical Condition"? YES NO
If yes, where: _____

If no, please note only $2,500 of your personal injury protection (PIP) allowance will be released to cover your medical expenses. (Florida HB: 0119)

If yes, what was the name of the doctor who diagnosed your condition: _____

I certify that above listed insurance information is true and correct to the best of my knowledge and that any error or omission contained within this information may result in a denial of my claims or a delay in the timely filing of my claims.

_____ _____
Signature of Patient Date

412 12th Avenue North, St. Petersburg, FL 33511 727-898-5001 Phone / 727-894-0554 Fax

Therapy and Sports Center of St. Petersburg
412 12 Avenue North
St. Petersburg, FL 33701-1120
Phone: (727) 898-5001
Fax: (727) 894-0554

THERAPY AND SPORTS CENTER
PHYSICAL THERAPY

10/02/2019

Patient Information:

Patient Name:	**DOB:**
Address:	**Apt #:**
City:	**State:**
Zip:	
SSN:	
Cell Phone:	**Work Phone:**
Home Phone:	**E-Mail Address:**

Treatment Information:

Primary Complaint:	**Date of Onset:**_____ **Date of Surgery:**_____
Referring MD:	**MD Phone Number:**
Primary Care Doctor:	**PCP Phone Number:**

Emergency Contact:

Name:	
Phone:	**Relationship:**

Employment Information:

Employer Name:	**Phone Number:**
Job Title:	
Job Status (circle all applicable): Full-Time Part-Time Full-Duty Modified-Duty Off-Work Retired	

Primary Insurance:

Insurance Name:	
ID #:	
Policyholder Name:	
Relation to Policyholder:	
Insurance Benefits:	**Annual Benefits:**
Coinsurance	**Authorizations:**

Additional Insurance Information:

Secondary Insurance Name:	Policyholder:
ID#:	Policyholder DOB:
Attorney Name:	Phone Number:
Adjustor Name:	Phone Number:

Liability Injury

Are you receiving care for injuries sustained in a Motor Vehicle Accident? Yes No
Are you receiving care for injuries from a Workman's Compensation Accident? Yes No
If yes, what state did the accident occur in? _____
What was the date of your accident? ____/_____/_____

Appointment Reminders

Would you like to receive appointment reminders via e-mail or text message? Yes No
Preferred method (circle one) : E-mail Text
If text, please provide your cell-phone **service provider:**
☐ Boost ☐ Cricket ☐ Sprint ☐ AT&T ☐ T-Mobile ☐ Verizon ☐
Other:_____

Have you recently had Home health? Yes No
If yes, when were you discharged?_____
Have you had Physical Therapy treatment elsewhere, this year? Yes No
If yes, where, and how many visits?_____

Patient or Guardian Agreement:

☐ I authorize the release of my information as requested by my insurance plan for payment.
☐ I give my consent for treatment rendered by Therapy and Sports Center.
☐ I understand that I have been given a description of my insurance benefits. I understand my insurance contract is the final basis for benefit determination and I am responsible for any amount not paid by my insurance company.
☐ I will strive to keep and arrive on time to my appointments and I understand multiple missed appointments may result in a status of non-compliance.

Signature of Patient or Guardian: _____ Date _____

Notice of Privacy Practices:

☐ I hereby acknowledge that I have been offered a copy of the Notice of Privacy Practices.

Signature of Patient or Guardian: _____ Date _____

THERAPY & SPORTS CENTER – Patient Medical History Form

Name: _____ D.O.B: _____ Date: _____

Referring Dr: _____ /#: _____ Primary Care Dr: _____ /#: _____

SOCIAL HISTORY: What is your occupation: _____ □ Full Time □ Part Time □ Unemployed □ Self Employed □ Retired □ Homemaker □ Student □ Other: _____

Do you live alone: Yes / No List any physical barriers in your residence that cause you difficulties: _____

Have you had a fall in the Past 12 months?: YES / NO If yes, How many times have you fallen?: _____

Have any of the falls resulted in an injury?: YES / NO If yes, what type of injury did you sustain?: _____

IS YOUR CONDITION RELATED TO AN AUTOMOBILE, WORK RELATED OR SLIP & FALL INJURY?: YES / NO

If yes, when was the date of injury?: _____ In what State did the injury occur?: _____

Claim Adjuster's Name: _____ Phone#: _____ Fax#: _____

Do you have an attorney?: Yes / No Attorney Name/Firm: _____ Phone #: _____

Have you had surgery for this injury? YES / NO Date of surgery: ___/___/___ Type of surgery: _____

MEDICAL HISTORY: Height: _____ Weight: _____ Do you/have you ever Smoked?: Yes / No

How would you rate your overall health: Excellent Good Fair Poor

Please list any allergies: _____

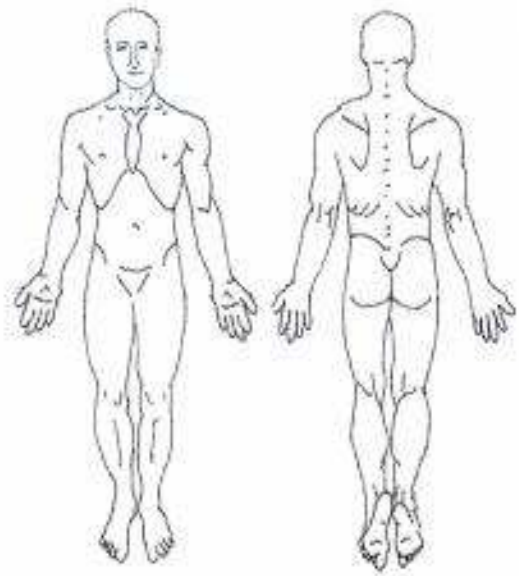
*Please list current Medications (*Medicare Recipients, Document on the Current Medications Form on the next page)

Do you now have or have you ever had ANY of the following?

	YES	NO
Asthma, bronchitis or emphysema	____	____
Shortness of breath/chest/pain	____	____
Coronary heart disease/angina	____	____
Heart attack or heart surgery	____	____
Do you have a pacemaker?	____	____
High blood pressure	____	____
Stroke/TIA Date: ___/___/___	____	____
Blood clot/emboli	____	____
Epilepsy/seizures	____	____
Anemia	____	____
Infectious diseases	____	____
Diabetes	____	____
Cancer or chemotherapy	____	____
Arthritis/swollen joints	____	____
Osteoporosis	____	____
Severe/frequent headaches	____	____
Vision/hearing difficulties	____	____
Dizziness/fainting	____	____
Weight loss/energy loss	____	____
Hernia	____	____
Sleeping prob/difficulties	____	____
Any joint/metal implants	____	____
Joint replacements	____	____
Shoulder injury/surgery	____	____
Elbow/hand injury/surgery	____	____
Neck/back injury/surgery	____	____
Knee injury/surgery	____	____
Leg/ankle injury/surgery	____	____
Are you pregnant?	____	____

On the body diagram below SHADE IN THE AREA(s) you are having pain, tingling or numbness with this episode

INDICATE: X for pain, = for numbness, * for tingling, # for burning



On a scale of 0 (no pain) to 10 (severe/disabling pain), rate your pain at at its BEST: _____ / WORST: _____

On a scale of 0% (worst) to 100% (best) what percentage of normal function are you able to perform? (This includes work performance, home activity, sports, socially with friends: _____

CURRENT EPISODE

When did your symptoms this episode start: Date: _____ Describe your symptoms: _____

How often do you experience your symptoms?: Constantly: _____ Frequently: _____ Occasionally: _____ Rarely: _____

How much have your symptoms interfered with your daily activities?:

Never: _____ A little bit: _____ Moderately: _____ Quite a bit: _____ Extremely: _____

Have you had similar symptoms in the past?: Yes: _____ / No: _____

Who did you see for your symptoms: No One: ___ Medical Doctor: ___ Chiropractor: ___ Physical Therapist: ___ Other: _____

What treatment(s) did you receive?: X-Rays: ___ MRI: ___ CT Scan: ___ Surgery: ___ Other: _____

Patient Signature: _____ **Date:** _____

(MEDICARE PATIENTS)