Phone: 850.512.6949

Fax: 850.270.7806

[www.wavetherapyfl.com](http://www.wavetherapyfl.com)

**Patient Registration form**

1. Patient name (first, middle, last): Click or tap here to enter text. Today’s Date: Click or tap to enter a date.
2. Social Security #: Click or tap here to enter text. Email: Click or tap here to enter text.
3. Date of birth:Click or tap here to enter text. Gender: Click or tap here to enter text.
4. Address: Click or tap here to enter text.City: Click or tap here to enter text.State: Click or tap here to enter text.

Zip: Click or tap here to enter text.Phone: Click or tap here to enter text.

1. Emergency Contact: Click or tap here to enter text.Contact Phone #: Click or tap here to enter text.
2. Marital Status: Click or tap here to enter text.
3. Relationship to patient: Click or tap here to enter text. If a minor, parent/guardian name: Click or tap here to enter text.

Past Medical History

1. Have you had a Physical, Occupational or Speech Therapy with the past 12 months?

Yes  No

1. Have you received Home Health Care or Hospice Services within the past 12 months? Yes  No
2. Do you have advanced directive (power of attorney)?

Yes  (if yes, please provide copy) No

1. Do you take any medication?

Yes  (If yes, please list them on Number 17 below) No

1. Referring Physician Click or tap here to enter text.

Primary Care Physician Click or tap here to enter text.

1. Please state your current problem(s) Click or tap here to enter text.
2. Is this related to an auto accident? Yes If yes, date of accident: Click or tap here to enter text. State: Click or tap here to enter text. No
3. Is this a work-related injury? Yes  If yes, date of incident: Click or tap here to enter text.Employer: Click or tap here to enter text. No

Check if you currently have or have had any of the following:

Arthritis Diabetes Seizures

Asthma Heart Problems Stroke

Cancer High blood pressure Ulcers

Gout Circulation problems Other

If other, please specify: Click or tap here to enter text.

1. In general, how would you rate your overall health right now?

Excellent Very Good Good Fair Poor

1. List Medications:

Click or tap here to enter text.

Allergies: Click or tap here to enter text.

Major Surgeries: Click or tap here to enter text.

**Initial Screen**

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| 1. Have you had a fall in the past year? |  |  |
| 1. Do you have a fear of falling? |  |  |
| 1. Would you like your balance to be assessed? |  |  |
| 1. Do you experience dizziness or imbalance? |  |  |
| 1. Do you lose your balance when stepping up/down stairs or steps? |  |  |
| 1. Do you have a difficult time walking in the dark? |  |  |
| 1. Do you have visual deficits? |  |  |
| 1. Do you have osteoporosis, osteoarthritis or joint pain? |  |  |
| 1. Do you take bone and/or joint supplements? |  |  |
| 1. Do you experience muscle aches, pains and/or muscle cramping? |  |  |
| 1. Do you have foot and/or ankle pain/discomfort |  |  |
| 1. Do you currently wear shoe inserts? |  |  |
| 1. Do you have pain and/or physical challenges that effect your mobility? |  |  |

**Consent for Treatment**

I hereby authorize to receive care at Wave Therapy, LLC. I understand that receiving physical therapy may involve engagement of musculoskeletal tissue that may cause soreness. Additional risks include, but are not limited to cardiovascular, muscle, ligament, joint or disc injury. Symptomatic aggravation of your current condition is possible. Furthermore, I understand that the provider may need to perform mobilization technique, message technique, manual traction, distraction, and other movement modalities and services that may produce brief soreness and discomfort. It is my responsibility to communicate any difficulties that I am having during treatment or any medical activity changes to my provider. Please acknowledge consent with full knowledge of the nature and risks of evaluation and treatment program with your signature.

Print name: Click or tap here to enter text.Signature: Click or tap here to enter text.

(I understand that typing my name here accounts for my signature)

Date: Click or tap to enter a date.

**Financial Policy and Benefit Assignment**

I, the undersigned, hereby assign all medical benefits, IE: Medicare, private insurance, major medical benefits, Workers Compensation and any other health plans to which I am entitled to Wave Therapy, LLC. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize Wave Therapy, LLC to release all medical information and records necessary to secure payment for services rendered.

**Primary Insurance**

1. Carrier: Click or tap here to enter text. Policy #: Click or tap here to enter text.

Group: Click or tap here to enter text.

1. In network: Yes No Subscriber name: Click or tap here to enter text.

Subscriber DOB:Click or tap here to enter text.

**Secondary insurance**

1. Carrier: Click or tap here to enter text.Policy #: Click or tap here to enter text.

Group:Click or tap here to enter text.

1. In network: Yes No Subscriber name: Click or tap here to enter text.

Subscriber DOB: Click or tap here to enter text.

This coverage determination does not guarantee payment by insurance. We encourage you to call customer service to verify your eligibility and coverage as described above. It is our policy to bill your insurance carrier or other provider of medical benefits as a courtesy to you, although you are responsible for the entire bill when the services are rendered. Required co-payments and estimated co-insurances are to be made as services are rendered and arrangements are to be made for your payment of all amounts not covered by your medical benefits or estimated co-insurances as soon as those amounts are known. If your medical benefits are not paid within 30 days the balance will be due in full.

**All coinsurance percentage is paid at time of services are estimated. Your actual liability may be more. You are responsible for any difference between the estimated and actual co-insurance due.**

If any payments of medical benefits are made directly to you for services rendered by Wave Therapy, LLC, you must promptly remit such payment directly to Wave Therapy, LLC. If you are a worker’s compensation patient the above policy does not apply to you. Be advised, however, that you may be responsible for your charges if your workers compensation claim is successfully controverted. If you fail to make timely payment for any amount for which you are responsible, you will be responsible for all cost of collection, including court costs, collection agency fees, and/or a reasonable attorney fee.

**Please give the office 24 business hours to cancel or reschedule your appointment, otherwise you may be subject to a $25 administrative fee.**

I have read the above information, and/or it has been explained to me and I accept the terms and conditions of the above and will be responsible for the payment of my account.

Print Name:Click or tap here to enter text. Signature: Click or tap here to enter text.

(I understand that typing my name here accounts for my signature)

Date: Click or tap to enter a date.

**Privacy Policy**

**The following notice describes how your medical information may be used and disclosed, and how you can get access to this information. Please review the information carefully.**

* Your confidential Healthcare information may be released to other Healthcare professionals within the clinic for the purpose of providing you with quality Care.
* Your confidential Healthcare information may be released to your insurance provider for the purpose of the clinic receiving payment for providing you with needed Healthcare Services.
* Your confidential Healthcare information may be released to the public or law enforcement officials in the event of an investigation and what you are a victim of abuse, a crime, or domestic violence.
* Your confidential health information may not be released via text message. You are advised to call your Healthcare professional should you have any questions or concerns.
* Your confidential Healthcare information may be released to other healthcare providers in the event you need Continued Care.
* Your confidential Healthcare information may be released to the Public Health Organization or federal organization in the event of communicable disease or to report a defective device or untoward event to a biological product
* Your confidential health information may not be released for any other purpose than that which it is identified in this notice.
* Your confidential Healthcare information may be released only after receiving written authorization from you. You may revoke your permission to release confidential Healthcare information at any time.
* You may be contacted by the clinic by phone, text or email to remind you of any appointments, Health Care treatment options or other health services that may be of interest to you.
* You have the right to restrict the use of your confidential Healthcare information. However, the clinic may choose to refuse your restriction if it is income conflict of providing you with Quality Healthcare in the event of an emergency situation.
* You have the right to receive confidential communication about your health status and photocopy any all portions of your Healthcare information.
* You have the right to make changes to your health care information.
* You have the right to know who has accessed your confidential Healthcare information and for what purpose.
* You have the right to possess a copy of this Privacy notice upon request.  This copy can be in the form of an electronic transmission or on paper.
* The clinic is required by law to protect the privacy of its patients, it will keep confidential any and all patient Healthcare information and will provide patients with a list of Duties and practices that protect confidential Healthcare information.
* The clinic will abide by the terms of this notice. The clinic reserves the right to make changes to this notice and continue to maintain the confidentiality of all Healthcare information.
* All complaints will be investigated. No personal issue will be ready for filing a complaint with the clinic.
* You have the right to complain to the clinic if you believe your rights to privacy have been violated. For further information about this privacy notice, please contact: <info@wavetherapyfl.com>. This notice is effective as of 4/10/18. This date must not be earlier than the date on which the notice is printed or published.

Print Name:Click or tap here to enter text.Signature:Click or tap here to enter text.

(I understand that typing my name here accounts for my signature)

Date:Click or tap to enter a date.

Is there anyone you would like to grant access to your medical records? If so, please list them here:

1) Click or tap here to enter text.

2) Click or tap here to enter text.

3) Click or tap here to enter text.

**Patient Bill of Rights**

**A patient has the right to:**

* Be treated with courtesy and respect, with appreciation of his or her dignity, and with protection of privacy.
* Receive a prompt and reasonable response to questions and requests.
* Know who is providing medical services and who is responsible for his or her care.
* Know what patient support services are available, including if an interpreter is available if the patient does not speak English.
* Know what rules and regulations apply to his or her conduct.
* Be given by the health care provider information such as diagnosis, planned course of treatment, alternatives, risks, and prognosis.
* Refuse any treatment, except as otherwise provided by law.
* Be given full information and necessary counseling on the availability of known financial resources for care.
* Know whether the health care provider or facility accepts the Medicare assignment rate, if the patient is covered by Medicare.
* Receive prior to treatment, a reasonable estimate of charges for medical care.
* Receive a copy of an understandable itemized bill and, if requested, to have the charges explained.
* Receive medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
* Receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
* Know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such research.
* Express complaints regarding any violation of his or her rights.

**A patient is responsible for:**

* Giving the health care provider accurate information about present complaints, past illnesses, hospitalizations, medications, and any other information about his or her health.
* Reporting unexpected changes in his or her condition to the health care provider.
* Reporting to the health care provider whether he or she understands a planned course of action and what is expected of him or her.
* Following the treatment plan recommended by the health care provider.
* Keeping appointments and, when unable to do so, notifying the health care provider or facility.
* His or her actions if treatment is refused or if the patient does not follow the health care provider’s instructions.
* Making sure financial responsibilities are carried out.
* Following health care facility conduct rules and regulations.

**Right to Report**

Per Florida Statute- 408.810 Minimum licensure requirements

(5)(a) On or before the first day services are provided to a client, a licensee must inform the client and his or her immediate family or representative, if appropriate, of the right to report:

1. **Complaints**. The statewide toll-free telephone number for reporting complaints to the agency must be provided to clients in a manner that is clearly legible and must include the words: “To report a complaint regarding the services you receive, please call toll-free (**1-888-419-3456**).”

2. **Abusive, neglectful, or exploitative practices**. The statewide toll-free telephone number for the central abuse hotline must be provided to clients in a manner that is clearly legible and must include the words: “To report abuse, neglect, or exploitation, please call toll-free (**1-800-962-2873**).”

3. **Medicaid fraud**. An agency-written description of Medicaid fraud and the statewide toll-free telephone number for the central Medicaid fraud hotline must be provided to clients in a manner that is clearly legible and must include the words: “To report suspected Medicaid fraud, please call toll-free (**1-866-762-2237**).”

**Consent for Treatment of a minor**

I give my permission for my child to be medically evaluated and treated by Wave Therapy, LLC. I understand that it may be necessary to perform diagnostic test during treatment. I also understand that patients ages 12 or older may be treated within the clinic without a chaperone. I reserve the right to notify Wave Therapy, LLC. in writing if a personally designated chaperone will be required at any point in my child’s treatment. Furthermore, if my child requires a personally designated chaperone, I retain the responsibility of coordinating appointments to meet the needs of the patients customized physical therapy action plan.

1. Complete Physical Therapy Evaluation
2. Physical Therapy Treatments (including manual stretching, soft tissue mobilization, myofascial release, joint mobilization, and electrical stimulation)
3. First Aid and Emergency Care

I DO NOT give permission for the following services to be performed without my presence in the office at the time said services are performed:

Click or tap here to enter text.

My child may be accompanied by the following person(s):

Unaccompanied

Caregiver (name): Click or tap here to enter text.

Other (Name + relationship): Click or tap here to enter text.

I give permission for the provider treating my child to share any relevant health information with the person accompanying my child.

Child’s name:Click or tap here to enter text. Date: Click or tap to enter a date.

Parent/Guardian Name: Click or tap here to enter text.

Parent/Guardian Signature: Click or tap here to enter text.

(I understand that typing my name here accounts for my signature)