BayLife
Physical Therapy & Rehabilitation, Inc.

QPR
Quality Performance Rehabilitation
"THE BODY MECHANICS"

Patient Information

Patient Name: _____Birth Date: _____Gender: M/F SSN:_____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Mobile: _____ Work Phone: _____

Occupation: _____ Email: _____

Referring Physician: _____ Referral Source: _____

Emergency Information

Contact Name: _____ Contact Phone: _____ Relationship: _____

Guarantor **Same as above** ☐

Guarantor Name: _____ Contact Phone: _____ Relationship: _____

Phone: _____ Mobile: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Information

Insurance Name: _____ Phone: _____

ID #: _____ Name of Insured: _____

Attorney Information (if applicable)

Attorney Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

QUALITY PERFORMANCE REHABILITATION, INC.
CONSENT TO TREAT

By executing this consent to treat form, the undersigned hereby warrants and represents that he/she has agreed to participate in a Physical Therapy program under the supervision of Baylife/Quality Performance Rehabilitation, Inc. herein known as Baylife/QPR. The undersigned further warrants and represents that the undersigned has been advised by a medical professional prior to undertaking this physical therapy program. The undersigned acknowledges that a physical therapy program may include such things as weight training, cardiovascular exercises, nutritional counseling, and any other element deemed appropriate under the professional guidance of Baylife/QPR. The undersigned acknowledges that a medical professional has determined it to be appropriate for the undersigned to engage in a physical therapy program proposed by Baylife/QPR. The undersigned hereby gives it permission to Baylife/QPR to run any physical therapy evaluation test that it desires, in order to test the undersigned's current fitness level. Such test may be used by the center for the purpose of creating an appropriate physical therapy program for the undersigned. Such tests are NOT medical tests and should not be deemed as such. If it is deemed appropriate, I give further consent to treatment (as outlined and described to me personally) of the proposed treatment.

Signature of Patient _____Date _____

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ASSIGNMENT OF BENEFITS/POLICY RIGHTS

I, the undersigned patient hereby assigns the rights and benefits of insurance of the applicable personal injury protection, medical payments, and/or other insurance to Baylife/Quality Performance Rehabilitation, Inc. For services rendered to the undersigned patient and covered by Personal Injury Protection (PIP) coverage or other insurance in accordance with Florida Statute 627.735 (5).

The undersigned agrees to pay any applicable deductible or co-payment *not* covered by the insurance or other applicable auto/PIP/Medpay coverage. If this is an auto accident, Baylife/QPR will file to the auto if auto benefits have been exhausted, will subsequently file to the health insurance on file.

For Commercial Insurance and Medicare, to the best of our knowledge the deductible is: $_____ per year and copay/coinsurance is: $_____. Most insurance companies require that the yearly deductible must be met before the copay/coinsurance will apply.

If the insurance company makes payments directly to the patient, the patient will agree to immediately remit these funds to Baylife/Quality Performance Rehabilitation, Inc. to be applied to the outstanding account balance or the undersigned will be billed directly for said balance.

If this is a worker's compensation case, all bills will be paid in full by: _____
And the patient is *not* responsible for the any outstanding balance.

In the event there is *no* insurance to file, Baylife/QPR cash rate is $75 for the evaluation and $50 each visit thereafter.

This assignment includes but is not limited to all rights to collect benefits directly from the insurance company for services that I have received and all rights to proceed against the insurance company obligated to provide benefits in any action including legal suite if any reason the insurance company fails to make payments or benefits to which I am due. Specifically, this assignment includes the right to collect payment for the reasonable costs connected with the copying and mailing records to the insurer at the insures request and accordance with the Florida Statute 627.736 (6). This assignment also includes any right to recover attorney's fees and costs for such action he/she wishes and understand and agree that the attorney selected by them may be different than the attorney handling my personal injury/ bodily injury claim or case. As part of this assignment of rights and benefits, which only becomes binding upon the insurance carrier upon there receipt of said assignment after it having been executed and dates by the health care provider, I hereby instruct the insurance carrier that in the event the subject medical benefits are disputed for any reason including medical reasonableness and or necessity, that the amount of benefits claimed by Baylife/Quality Performance Physical Therapy is to be set aside and not disbursed until the dispute is resolved. As part of this assignment of rights and benefits he/she it may exercise their legal rights. I understand that any person who knowing and with intent to injure defraud or deceive any insurance company files a statement containing false, incomplete or misleading information is guilty of a felon of the third degree. **I have read the information herein and is true to the best of my knowledge and belief.**

I, the undersigned patient acknowledge receipt of the "Notice of privacy Practices" and the "Patient Rights and Responsibilities" document. I have read and understand the "Consent to Treat" document and by witness of my signature have assigned my benefits of insurance to Baylife/Quality Performance Rehabilitation, Inc.

Signature of Patient_____Date_____

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In general, the HIPAA privacy rule gives individuals the right to requests a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential correspondence to the office instead of the individuals home.

I wish to be contacted in the following manner (check all that apply)

☐ Home Telephone _____

☐ Leave message with detailed information

☐ Cell Phone _____

☐ Leave message with detailed information

☐ Leave message with call back number only

☐ Email _____

Written Communication ☐ Mail to my home address

_____ _____

Patient's Signature Date

_____ _____

Print Name Birth Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.
Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.
NOTE: Uses and disclosures for TPO may be permitted without prior consent in an emergency.
PLEASE ENTER ANY PERSON AUTHORIZED ACCESS TO ANY OF YOUR INFORMATION INCLUDING VISIT DATES/TIMES THAT OUR CLINIC MAY OBTAIN FROM YOU BELOW:

Date	Disclosed to Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosed	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type key: T = Treatment Record, P= Payment Information, O= Healthcare Operations
(3) Enter how disclosure was made: F= Fax, P= Phone, E= Email, M= Mail, O= Other

Release of Information Request

By witness of my signature, I hereby give permission to my insurance company and/or physician to release information regarding my benefits or medical records.

Signature of Patient _____ **Date** _____

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NO SHOW/CANCELLATION POLICY

We do not charge for no show appointments, but we do set aside (1) hour of treatment time for your therapy. If you are going to cancel, please notify us within 24 hours of your scheduled appointment.

If you are later than 20 minutes for an appointment, you may need to reschedule.

Please keep in mind that any missed appointments will jeaopardize your therapy regimen. Your Physician ordered a recommended amount of visits for Physical Therapy. 3x's -4 wks or 2x's – 3 wks. It is the patient's responsibility to follow your Plan of Care. If for some reason you have to cancel your visit, please reschedule the same day or an alternate date in the same week.

_____ _____

SIGNATURE DATE

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Welcome! In order to help the therapist, evaluate you properly, we need to collect some information. Please fill out both pages. If you are not sure, leave it blank as the therapist will be reviewing the information with you during your evaluation.

Name: _____ DOB_____ Age: _____Marital Status: M S W D
Occupation:_____ Currently working? YES NO LIGHT DUTY
Hobbies/Sports/Lifestyle: _____
The problem I am here for is: _____
_____

Other medical conditions I had in the past or currently have are: CIRCLE YES OR NO

Cancer	YES NO	Diabetes	YES NO
Breathing Problems	YES NO	Stroke	YES NO
High Blood Pressure	YES NO	Circulation Problems	YES NO
Heart Problems	YES NO	Stomach Ulcers	YES NO
Depression	YES NO	Drug/Alcoholism	YES NO
Thyroid Disease	YES NO	Fibromyalgia	YES NO
Rheumatoid Arthritis	YES NO	Osteoarthritis	YES NO
Herniated Disc	YES NO	Multiple Sclerosis	YES NO
Diseases of the Brain	YES NO	Diseases of the Nerves	YES NO
Peripheral Neuropathy	YES NO	History of Falling	YES NO
Pneumonia	YES NO	Tuberculosis	YES NO
Blood disorders	YES NO	Anemia	YES NO
Kidney disease	YES NO	Osteoporosis	YES NO
Joint Sprains	YES NO	Broken bones	YES NO
Pregnant	YES NO MAYBE	Post Menopause	Yes NO
Seizure	YES NO	Pacemaker	YES NO

Surgeries or major hospitalizations I have had- Date and Reason/Surgery:
1._____ 2. _____

3. _____ 4. _____
I am allergic to:
Medications: **Latex allergy? YES NO**
_____
Food: _____
Other: _____

Have any of your parents or siblings had any of the following problems: CIRCLE YES OR NO

Cancer	YES NO	Diabetes	YES NO
Heart Problems	YES NO	Stroke	YES NO
High Blood Pressure	YES NO	Depression	YES NO
Drug/Alcoholism	YES NO	Kidney Disease	YES NO
Rheumatoid Arthritis	YES NO	Ankylosing Arthritis	YES NO

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Do you smoke cigarettes? YES NO ___ packs/day x ____ years; **I quit:** _____
Do you chew tobacco? YES NO # _____ Hrs per day x _____years; **I quit**: _____
# of Caffeinated drinks per day: _____
# of Alcoholic drinks per weekday: _____; per weekend day: _____

List **all** medications you **are currently taking** including over the counter, vitamins, patches, herbals and any medication, **whether prescribed or not prescribed** by a physician over the last week:

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____
7. _____ 8. _____ 9. _____
10. _____ 11. _____ 12. _____

Please circle any of the following if you have taken them in the last week:
Aspirin Ibuprofen Advil Aleve Motrin Naprosen/Naproxen Tylenol

Therapist's notes:

Name any medical practitioners you have seen in the last 6 months including physicians, chiropractors, physical therapists, and mental health professionals:
Name: _____ Specialty: _____
Name: _____ Specialty: _____
Name: _____ Specialty: _____

CIRCLE YES OR NO. Indicate YES for any complaint that is NEW or CHANGED recently:

Weight/loss gain	YES NO	Heart racing	YES NO
Change in vision	YES NO	Shortness of Breath	YES NO
Change in hearing	YES NO	Cough not from cold	YES NO
Dizziness	YES NO	Pain not relieved by rest	YES NO
Lightheadedness	YES NO	Stiffness not relieved by moving	YES NO
Vertigo	YES NO	Pain worse during sleep	YES NO
Heart palpitations	YES NO	Increased stress	YES NO
Insomnia	YES NO	Night sweats	YES NO
Fevers/chills	YES NO	Redness in eye	YES NO
Bruise/bleeding	YES NO	Numbness/Tingling/Burning	YES NO
Swelling	YES NO	Urinary incontinence	YES NO
Swallowing difficulty	YES NO	Difficulty starting urinating/pain	YES NO
Blood in Urine/stool	YES NO	Constipation/Diarrhea	YES NO
Weakness/fatigue	YES NO	Nausea/Vomiting	YES NO
Tremors	YES NO	Rashes or open sores	YES NO
Deep aching pain	YES NO	Sexual difficulties	YES NO

During the past month have you been feeling down, depressed or hopeless? YES NO
During the past month have you been bothered by having little interest or pleasure in doing things? YES NO