

# WHITE SANDS PHYSICAL THERAPY & AQUATICS

## MEDICAL HISTORY

**Patient Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Referring Physician or name of the doctor who will be signing any reports generated by your therapist: \_\_\_\_\_

Diagnosis or reason for Physical Therapy: \_\_\_\_\_

### Check all current or past conditions:

Back Pain	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	Tingling in Legs/Feet	<input type="checkbox"/>
Spinal Stenosis	<input type="checkbox"/>	Hysterectomy	<input type="checkbox"/>	Total Knee Replacement	<input type="checkbox"/> L <input type="checkbox"/> R
Back Surgery	<input type="checkbox"/>	Balance	<input type="checkbox"/>	Total Shoulder Replacement	<input type="checkbox"/> L <input type="checkbox"/> R
Disc Problems	<input type="checkbox"/>	Pregnant	<input type="checkbox"/>	Total Hip Replacement	<input type="checkbox"/> L <input type="checkbox"/> R
History of Sciatica	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Cancer: Type _____	<input type="checkbox"/>
History of Scoliosis	<input type="checkbox"/>	COPD	<input type="checkbox"/>	Fear of swimming pool	<input type="checkbox"/>
Knee Pain	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	Open Wound/Sore	<input type="checkbox"/>
Hip Pain	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Skin Rashes	<input type="checkbox"/>
Shoulder Pain	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Osteoarthritis (Degenerative)	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	Memories Issues	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>
Neck Stiffness	<input type="checkbox"/>	Dementia	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	Alzheimer	<input type="checkbox"/>	Osteopenia	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	Diabetes	Type 1 <input type="checkbox"/>	Anemia	<input type="checkbox"/>
Heart Surgery	<input type="checkbox"/>		Type 2 <input type="checkbox"/>		
Pacemaker / Defibrillator	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	Infection Disease	<input type="checkbox"/>
CVA Stroke	<input type="checkbox"/>	Thyroid	Hypo <input type="checkbox"/> Hyper <input type="checkbox"/>	Vision Problems	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	Bladder Urgency	<input type="checkbox"/>	DNR	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	Bladder Incontinence	<input type="checkbox"/>	Metal Implant	<input type="checkbox"/>
Parkinson	<input type="checkbox"/>	Bowel Urgency	<input type="checkbox"/>		
Headaches	<input type="checkbox"/>	Bowel Incontinence	<input type="checkbox"/>		
Epilepsy or Seizure	<input type="checkbox"/>	Peripheral Neuropathy	<input type="checkbox"/>		
Dizziness/Fainting	<input type="checkbox"/>	Tingling in Arms/Hands	<input type="checkbox"/>		
Falls (last fall date)	<input type="checkbox"/>	Hearing Problems	<input type="checkbox"/>		

**Staff Initials:** \_\_\_\_\_

7157 Curtiss Ave.  
Sarasota, FL 34231

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Patient Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Do you live alone:  Yes  No

Living partner disabled:  Yes  No

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

**SURGERIES:** Please list with Date and Details:

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**OTHER HEALTH ISSUES (Including Chronic Conditions):**

Please list: \_\_\_\_\_

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**ALLERGIES:**

Please list: \_\_\_\_\_

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I have listed all my medical conditions to the best of my knowledge.

I attest that the information provided by me on this medical history form is correct.

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

*Staff Initials:* \_\_\_\_\_

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# WHITE SANDS PHYSICAL THERAPY & AQUATICS

## MEDICATIONS LIST

**Patient Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

Please provide us with a complete list of your medications for our files. Please include any Over the Counter medications, Vitamins or Herbal Supplements you may be taking. If you need a second page, please let us know.

***Please also list any OTC pain or anti-inflammatory medications even if only taken as needed. (ie: Tylenol, Advil, Motrin, Aleve, etc)***

#	Prescription/Over the Counter/Vitamins Supplements/Herbal Supplements	Dosage	O - Oral I - Injection C - Cream S - Sublingual	Times per day. If only used as needed circle PRN	What is it used for? (i.e.: heart, Blood pressure, kidney)
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					

Check if apply:

- I am currently not using any medications.
- Please see my list of medications provided on separate page.
- I verify that the above list of medications/Supplements is correct and contains all that I am currently taking.

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

**Staff Initials:** \_\_\_\_\_

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# WHITE SANDS PHYSICAL THERAPY & AQUATICS

## PATIENT DEMOGRAPHICS

### PATIENT INFORMATION (Please Print)

Patient Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Gender:  Male  Female

Home Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Out of State Address & Phone #: \_\_\_\_\_

### EMERGENCY CONTACT

Name: \_\_\_\_\_ Home/Cell Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

### Electronic Communication:

White Sands Physical Therapy & Aquatics believes strongly in protecting the privacy of our patients. When you provide this information to us, it is only used as a way to communicate with you. In order to protect your privacy, no confidential or personal information will be sent from White Sands Physical Therapy & Aquatics via email or text messaging. White Sands Physical Therapy & Aquatics does not share the names, e-mail addresses, and/or telephone numbers of patients with any other company, or with any other patient.

- Yes, please sign me up to receive e-mail and/or text messaging.
- I do not wish to be contacted via email. (Text messaging only)
- I do not wish to be contacted via text messaging. (Email only)
- I do not wish to be contacted by either text messaging or email.

Email: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

### Authorization to discuss your care with Family or Friends

White Sands Physical Therapy & Aquatics is authorized to discuss health, appointment and/or billing information pertaining to the above patient to the entities below.

- Leave information on voice mail: Home  Cell  Work
- Share information to \_\_\_\_\_ Relationship: \_\_\_\_\_
- Share information to: \_\_\_\_\_ Relationship: \_\_\_\_\_

White Sands Physical Therapy will bill your insurance as a courtesy to you; however, if no payment is received from your insurance within 45 days of billing, payment in full will be expected from you. I hereby authorize my benefits, including Medicare, to be paid directly to White Sands Physical Therapy and authorize the release of medical information necessary to process claims.

\_\_\_\_\_  
Patient Signature  
Staff Initials: \_\_\_\_\_

\_\_\_\_\_  
Date

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Patient Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## PHYSICIAN

Date of Next Appointment with Referring Physician: \_\_\_\_\_

Have you received any physical or speech therapy in this calendar year? Yes  No

How many visits: \_\_\_\_\_ Place of service: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

What area(s) of the body was treated? \_\_\_\_\_

Have you had medical care in your home in the past 60 days? Yes  No

How many visits: \_\_\_\_\_ If yes, please give date(s): \_\_\_\_\_

Agency that provided care: \_\_\_\_\_

**\* Medicare will not pay for Outpatient Physical Therapy if patient is receiving any type of Home Health Care. This includes Home Health Nursing, Home Health Respiratory, Home Health Aide, and/or any other type of Home Health Care. It is the patient's responsibility to inform the Therapist or office staff if the patient is currently under Home Health Care. If WSPTA is denied payment because of Home Care Services, then the patient is responsible for the full cost of care provided by WSPTA.**

**Patients Initials:** \_\_\_\_\_

**\* Patient that are scheduled to go in the pool, please be aware, NO OPEN WOUNDS IN THE WATER. If you are to have a biopsy done you will not be able to go into the pool for two weeks after having a biopsy and a written release from your MD will be required to resume pool treatment. We request that for you benefit, all biopsies be scheduled after you have completed therapy (unless otherwise noted by your doctor).**

**Patients Initials:** \_\_\_\_\_

**\* WSPTA strives to provide the best therapy in the area, any changes in your health while enrolled in our program makes a difference in your care. Please report any falls or injury immediately, your therapist will need to evaluate your condition to make sure that is safe to continue treatment. In the case of a serious injury or fall, a Doctor's note may be required to resume treatment.**

**Patients Initials:** \_\_\_\_\_

## ACCIDENT:

Are your symptoms related to an accident? Yes  No  Auto Accident? Yes  No

Accident Date: \_\_\_\_\_ Claim No.: \_\_\_\_\_

Is the Case Settled? Yes  No

Adjuster Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Attorney: \_\_\_\_\_ Phone No.: \_\_\_\_\_

**I attest that the information provided by me on this patient information form is correct.**

**Patient Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

Staff Initials: \_\_\_\_\_

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# WHITE SANDS PHYSICAL THERAPY & AQUATICS

Patient Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## Acknowledge of Receipt of Notice of Privacy Practices

I have received or have been offered a copy of the Notice of Privacy Practices from White Sands Physical Therapy & Aquatics.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

## Authorization for treatment, Acknowledgement of Financial Responsibility and Assignment of Benefits

I acknowledge that I am legally responsible for all charges in connection with the medical care, treatment and therapy provided by representatives and personnel of White Sand Physical Therapy & Aquatics, LLC. I consent to the release of any medical information, including diagnosis and the records of any treatment or examination rendered to me for such services to third party payers, health care practitioners and/or managed care organizations. I hereby assign, authorize and direct payment of my medical benefits to White Sands Physical Therapy & Aquatics, LLC. I understand that White Sands Physical Therapy & Aquatics, LLC will assist me in submitting my claims to my insurance carrier. I understand my insurance carrier may not approve or reimburse my medical services in full due to benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand I am responsible for fees not paid in full, co-payments, policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law. Furthermore, any information given to us may be used for the collection of payments for services provided.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

## NO SHOW AND CANCELLATION POLICY

An appointment with a White Sands Physical Therapy and Aquatics therapist reserves a period of time just for you. A cancelled appointment or a no show keeps others from having access to that therapist.

- ❖ We require at least 24 hours' notice of cancellation in advance of your scheduled appointment.
- ❖ All no shows and late cancellations for appointments will be charged \$25.00 for any missed appointment (that includes any portion of your treatment cancelled at the last minute).
- ❖ Please cross check your White Sands schedule against your calendar at home for any conflict that would result in a cancellation fee.
- ❖ This fee must be paid prior to receiving future services.
- ❖ Chronic Cancellations will cause to cancel all patients schedule.
- ❖ Medical insurance can not be billed for missed appointments.
- ❖ I understand that I must call to cancel my appointment 24 hours prior to my scheduled appointment time. **There will be a \$25.00 No call/No show fee assessed when notification is not given for a missed appointment without 24 hours' notice.**

I have read, understand and agree with the provision of this cancellation policy.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Staff Initials: \_\_\_\_\_

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