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

7157 Curtiss Ave.
Sarasota, FL 34231

WHITE SANDS PHYSICAL THERAPY & AQUATICS

Patient Last Name: ______________________________ **First Name**: __________________ **DOB:** _________________

Do you live alone? ☐ Yes ☐ No   Living partner disabled? ☐ Yes ☐ No

Do you smoke or use other Tobacco Products? ☐ Yes ☐ No

Height: ________ Feet _________ Inches   **Weight:** ____________ Pounds

We recommend that you consult with your general practitioner about any weight management question. **Patients Initials:_____**

SURGERIES: Please list with Date and Details:

____

____

____

____

OTHER HEALTH ISSUES (Including Chronic Conditions):

Please list: ____

____

____

____

____

ALLERGIES:

Please list:____

____

☐ 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:* ____**
Rev. 06.16.21

7157 Curtiss Ave.
Sarasota, FL 34231

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: ____
Rev. 06.16.21

7157 Curtiss Ave.
Sarasota, FL 34231

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: ______________________________________

I reviewed the information and made any necessary changes.

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 **Date**

Staff Initials: ____
Rev. 06.16.21

7157 Curtiss Ave.
Sarasota, FL 34231

WHITE SANDS PHYSICAL THERAPY & AQUATICS

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 Home Health Care in the past 60 day? Yes ☐ No ☐ How many visits: ____

Have you been Discharged? Yes ☐ No ☐ If yes, Date of Discharge: _________Agency that provided care: ______________

Please Read & Initial:

*** 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 your 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: __________**

***Health disclaimer: I attest that as of today, I am not experiencing any symptoms of illness suggesting a Cold, flu or Covid-19 infection. I acknowledge White Sands Physical Therapy and Aquatics efforts in keeping the patients and staff safe by following and implementing CDC guidelines. I will promptly inform White Sands Physical Therapy and Aquatics if I become ill or come in contact with someone sick or positive for Covid-19, or if I myself, test positive for COVID-19.**
Patients Initials: __________

ACCIDENT: **Are your symptoms related to an accident?** Yes ☐ No ☐

Auto Accident? Yes ☐ No ☐ **Work Related Accident**: Yes ☐ No ☐

Accident Date: ______________________ Claim No.: ___________________________________

Adjuster Name: ____ Phone No.: __________________________

Is the Case Settled? Yes ☐ No ☐ **Is there or will there be a legal matter in this case?** Yes ☐ No ☐

If yes: Attorney: ____ Phone No.: __________________________

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

____ ___________________________

Patient Signature **Date**

Staff Initials: ____
Rev. 06.16.21

7157 Curtiss Ave.
Sarasota, FL 34231

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:* ____**
Rev. 06.16.21

7157 Curtiss Ave.
Sarasota, FL 34231