Giselle Werner, MPT

Quality Care and Convenient Physical Therapy in your Home

Outpatient Physical Therapy Services

585 Kenwood Dr. SW Vero Beach, Fl. 32968 Web Address: gisellewerner.com

Phone: (772) 321-0172 Fax :(772) 299 – 4295 Email: giselle@gisellewerner.com

CONSENT FORM

PLEASE INITIAL ON THE LINE AFTER READING EACH STATEMENT

CONSENT FOR PHYSICAL THERAPY: I give my consent to Giselle Werner,MPT to provide physical therapy to evaluate and treat my physical condition. In so doing, I understand, acknowledge and affirm that such services will likely involve bodily contact. _____

ASSIGNMENT OF BENEFITS: I hereby instruct and direct my insurance benefits be made directly to Giselle Werner, MPT for any professional and medical services delivered. If my current policy prohibits direct payment to Giselle Werner, MPT, I hereby instruct and direct that the check be mailed to the address above, and that Giselle Werner, MPT may deposit checks for therapy services made in my name. I authorize that a copy of this Assignment shall be considered as effective and valid as the original. I also authorize Giselle Werner, MPT to initiate a complaint to the Insurance Commissioner for any reason on my behalf. _____

GUARANTEE OF PAYMENT: I understand that all payments designated as 'the patient's responsibility', such as co-insurances, deductibles and non-covered charges are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed "my responsibility" by the statement due date, including all amounts due for services billed by Giselle Werner, MPT but paid directly to me. I will be financially responsible for all charges whether or not paid by my insurance company or financially responsible party. _____

NO-SHOW/CANCEL: I understand that a $30 fee may be assessed on my next statement if I fail to cancel or reschedule a session with less than 24 hours notice (exception for acute illness/emergency). If I have more than three (3) no-show appointments or cancels any future appointments will be removed from the schedule, and my referring physician will be notified. _____

NOTICE OF PRIVACY PRACTICES: I have been given the Notice of Privacy Practices for Giselle Werner, MPT. I recognize that outside of purposes for treatment, payment, and certain healthcare operations or as permitted or required by law, I must give my written authorization to Giselle Werner, MPT to release any of my protected healthcare information. This may include release of therapy reports to any healthcare professionals other than the referring and primary care physicians. I will address any questions, concerns or complaints about the Notice or my medical information, to the address above, attention "HIPAA Compliance Officer". Additional copies of this Notice of Privacy Practices and HIPAA Privacy Statement are available upon request. _____

Release to take Picture: agree to allow Giselle Werner, MPT take pictures of me and /or my insurance information to place in my personal medical record. I understand that any pictures taken are treated as medical information and will be kept confidential in accordance with HIPPA guidelines_____

I have read and fully understand the above information.

Patient/Guardian Printed Name: _____

Patient/Guardian Signature:_____ **Date:**_____

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PATIENT INTAKE FORM

Name: _____ Date: _____

Address _____

HICN: _____

PTDiagnosis _____

Date of Birth: _____ Age: _____ Sex: _____

Phone: _____ Cell: _____

Dr: _____ Dr. Phone: _____ fax: _____

Email: _____ referred by: _____

Individuals who we may share your diagnosis &/or treatment: _____

_____

PRIMARY INSURANCE

Name: _____ Policy number: _____

Name of insured: _____ Group number: _____

Address of ins co: _____

Phone: _____ Relation to patient: _____

Effective date _____ Expiration date _____

*Co-pay amt: _____ *Deductible: _____

SECONDARY INSURANCE

Name: _____ Policy number: _____

Name of insured: _____ Group number: _____

Address of ins co: _____

Phone: _____ Relation to patient: _____

Effective date _____ Expiration date _____

*Co-pay amt: _____ *Deductible: _____

EMERGENCYCONTACT: _____ phone _____

_____

SIGNATURE OF PATIENT/GUARDIAN **DATE**

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MEDICAL HISTORY

Name: _____ Date: _____

Reason for Physical Therapy referral: _____

Onset date: _____ Ht: _____ Wt: _____

MRI/ X-Rays/CT scans: _____

_____

Current Medications: _____

_____

_____

Recent surgery or hospitalization (related to current problem) _____

_____ Date of surgery _____

Previous PT for this problem: Yes/No when and how long: _____

Previous PT, RN or Home health Services for this year: Y/N when and how long: _____

Other treatments for this problem: _____

Near falls or falls in the past year: _____ injuries: Yes/No _____

Please check if you have a personal history of any of the following:

□Diabetes	□Stroke/TIA	□Heart disease	□Congestive heart failure
□Paralysis	□Cancer	□Osteoarthritis	□Rheumatoid arthritis
□Osteoporosis	□Dizziness	□Kidney problems	□High blood pressure
□Seizures	□Lung disease	□Bladder problems	□Bowel problems
□Pacemaker	□Memory loss	□Numbness	□Joint replacements
□Chronic pain	□Swelling	□Liver problems	□Circulation problems
□Vision loss	□Hearing loss	□Speech problems	□Swallowing problems

Please note any diseases, conditions or injuries not listed above: _____

_____

_____

What do you wish to accomplish out of physical therapy? _____

_____

_____

SIGNATURE OF PATIENT/GUARDIAN **DATE**