Welcome to Physical Therapy Professionals, LLC

Our team of qualified professionals is happy to assist you throughout the rehabilitation process. Our staff is committed to exceeding your expectations and we are confident that we can make your recovery a positive experience.

Your Viera Staff

Christine
Office Staff/Patient Intake

Clarissa
Office Staff/Patient Intake

Laura Siviter, PT, DPT
Physical Therapist

Shardae Clemens, PTA
Physical Therapist Assistant

Erin Roesch, PT, DPT
Physical Therapist

Nancy Figulski, PT, Cert. MDT
Physical Therapist

Your Palm Bay Staff

Ashley
Office Staff/Patient Intake

Bernadette
Office Staff/Patient Intake

Laura Kaufman, PT, DPT
Physical Therapist

Randal Brown, MSPT
Physical Therapist

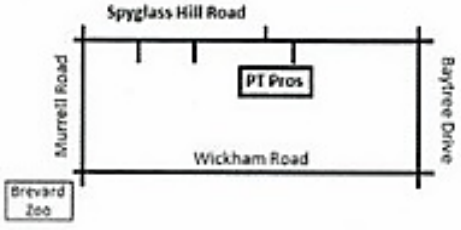
Jessica Ford, PT, DPT
Physical Therapist

Katie Fuller
Billing/Part Time

Your Administrators

Daryl Jacobs, PT, DPT
President/CEO

Shauna Jacobs, PT, DPT
Vice President/CFO



First Name: _____

Last Name: _____MI: _____

Preferred Name: _____

Sex: MALE / FEMALE

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Home Address: _____

City: _____State:_____ Zip: _____

Date of Birth: _____/_____/_____ Social Security Number: _____ - _____ - _____

How did you hear about Physical Therapy Professionals? _____

Emergency Contact: _____ Relationship:_____ Phone #:_____

For billing purposes if you have an alternate address please list below. Please include the date range that you normally reside at this secondary address:

Address: _____

City: _____ State: _____ Zip: _____ Dates: _____

Please provide your email address below to avoid charges for mailing requested medical records and / or outstanding financial statements. To ensure your privacy all email will be sent over a secure network and your address will not be shared publicly to any third party. If you have questions in regards to the above, please see the receptionist.

Email address: _____

I understand and agree that I am responsible for the balance of my account for any services rendered. I have read all the above information and the information provided is true and correct to the best of my knowledge. I will notify Physical Therapy Professionals of any changes with the above information. I hereby authorize any treatment(s) agreed upon with my physical therapist and my referring provider (if applicable) that are deemed medically necessary.

Patient Signature: _____ Date: _____/_____/_____

Cancellation Policy

We have multiple methods available to remind you of your appointments and it is your responsibility to attend scheduled appointments. Late notice cancellations or no shows harm our practice and will likely affect your recovery. If you fail to attend a scheduled appointment or cancel with less than 24 hours notice, any future no show or late notice cancellations will result in all future appointments being deleted. A $50 no-show fee will be charged before additional appointments can be scheduled and will be also be charged for any future missed visits without proper notification. Initials: _____

Home Health

Most insurance companies will not cover out-patient physical therapy if you are receiving Home Health Care of any kind at the same time. **By initialing below you indicate that you are currently not receiving any type of home care** including nursing, occupational therapy or physical therapy from a Home Health Agency. It is also your responsibility to inform us if you initiate home health care for any reason during the course of your treatment with us or you will be responsible for any denied payments that result from concurrent treatments. Initials: _____

Acknowledgement of Receipt of Notice of Privacy Practices

This facility will make every attempt to protect your privacy and personal information. We have provided a summary of your rights and protections under the federal health information privacy law. We would like to retain your signature to acknowledge the receipt of our notice of privacy practices.
You will receive a copy of the Privacy Practice Notice on your first appointment

I have received a copy of the notice of privacy practices at PT Professionals.
Initials: _____

Option to Give Access to Medical Records

I authorize_____(Examples: Spouse, Sibling, Parent, Caregiver) access to medical information pertaining to my treatment. Please note that PT Professionals will not share your information with any individual that are not involved with your case unless you specify otherwise.

Please note that if you are 18 years or older we can not release your information to any other individual that does not have a business associate agreement with PT Professionals and is not directly involved with your case unless you otherwise specify.

PHYSICAL THERAPY Professionals

Appointment Reminder Notifications

Would you like to receive free appointment reminder notifications via text message, phone call or e-mail message?

☐ Text Message (Phone Number): _____

☐ Phone Call (Phone Number): _____

☐ Email (Email Address): _____

☐ No Reminders

Email Newsletter

Would you like to be included on our email list to receive our newsletter and updated clinical information and health tips from PT Professionals?

☐ Email: _____

☐ Not Interested

DISCLAIMER

We will not use this information for any other purpose than to contact you via the PT Professionals mailing list & PT Professionals contact list. We WILL NOT pass your email address, phone number or other information to other companies. You may at any point have your details removed from our database by contacting our webmaster.

PHYSICAL THERAPY *Professionals*

Patient Name: _____Referring practitioner: _____

Is this a Work related Injury? □ Yes □No Is this related to an Auto Accident? □ Yes □ No
Is there an attorney involved in this case? □ Yes □ No

Have you had surgery for this condition? □Yes □ No If yes, date: _____

Have you received previous treatment for this condition? □Yes □ No If yes please describe:

_____

Are you a previous patient of PT Professionals? □ Yes □ No

Are you currently receiving or have you received in the last 30 days any home health, medical or chiropractic services rendered to you by any other agency? □Yes □ No If yes, please describe:

_____

Are you currently taking any medications **for this injury**? □YES □NO
□Anti Inflammatories □Muscle Relaxers □ Pain Medication □ Other: _____

At the present time, would you consider your overall health:
□ EXCELLENT □ VERY GOOD □ FAIR □ POOR

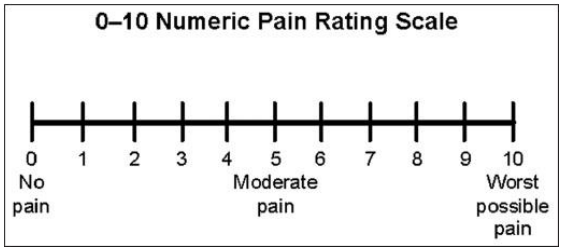
Females: Are you currently pregnant? □YES □ NO

Do you now have, or have you ever had any of the following?

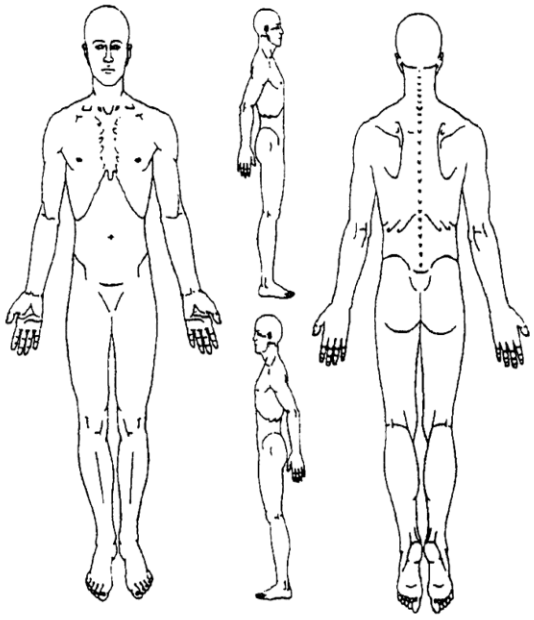
Pacemaker and/or defibrillator	□ YES	□ NO
Diabetes	□ YES	□ NO
Coronary Artery Disease/Angina	□YES	□ NO
Shortness of Breath/Chest Pain	□YES	□ NO
Heart Attack/Heart Surgery	□ YES	□ NO
Latex Sensitivity/Allergy	□ YES	□ NO
Blood Clot	□ YES	□ NO
High Blood Pressure	□ YES	□ NO
Osteoporosis	□ YES	□ NO
Pin/Metal Implants	□ YES	□ NO
Asthma, Bronchitis or Emphysema	□ YES	□ NO
Headaches	□ YES	□ NO
Dizzy Spells/Fainting	□ YES	□ NO
Stroke/TIA	□ YES	□ NO
Thyroid Trouble/Goiter	□ YES	□ NO
Joint Replacement	□ YES	□ NO
Infectious Disease (explain below)	□ YES	□ NO
Arthritis	□ YES	□ NO
Sleeping Problems	□ YES	□ NO
Do you Smoke?	□ YES	□ NO
Numbness/Tingling	□ YES	□ NO
Weakness	□ YES	□ NO
Unexplained Weight Loss/Gain	□ YES	□ NO
Hernia	□ YES	□ NO
Epilepsy/Seizures	□ YES	□ NO
Recent changes in Bowel/Bladder	□ YES	□ NO

Allergies: _____
Cancer (Please Explain):_____
_____

On a scale of 0-10,
(0 being no pain and 10 being at its worst)
Please rate your pain at best ____ at worst ____



Please mark the areas on the diagram below where you feel the pain.



Please list any other health conditions:
_____
_____
_____

Patient Signature:_____ Date: _____

PHYSICAL THERAPY Professionals

Patient Name: _____ D.O.B: _____

Medication List

*** This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications name, dosage, frequency and route of administration***

Medication	Dosage	Frequency	Administration Method

☐ I am not taking any Medications at this time.

Patient Signature:_____ Date: _____