



**Welcome to Beachside Physical Therapy!** We would like to thank you for making the decision to include us in your rehabilitative journey. The following is some information many of our patients ask about during their first visit. We hope that you find answers to some of your questions here but if not you are always free to

### **Physical Therapy: What to Expect**

After an examination that entails us asking several questions on your first visit your Physical Therapist (PT) will create goals for you to meet throughout your care as well as determine the methods that will be used to meet these goals. Your PT will use physical treatments, manual therapy, therapeutic exercises and other techniques specifically catered to your needs in order to help you meet your goals. Your PT may even assign “homework” – exercises for you to perform on your own at home. It is very important that you follow the PT’s instructions as compliance is the number one factor determining your rehabilitative success. During your time at Beachside your PT may add to, remove from, or alter your care plan to ensure your success in your treatment. Always notice the changes and continue to follow your PT’s instructions. Remember: they want you to get better!

During your treatment at Beachside Physical Therapy you will work with one or two additional PT’s other than the PT that performed your initial evaluation. **THIS IS OK.** All of the Physical Therapists at Beachside Physical Therapy are licensed and knowledgeable about your problems. Having more than one PT is beneficial to your care as each may have different methods of curing the same ailment. There are also scheduling benefits of having more than one PT: If one is booked during the time you need to schedule you can always book with the other. Beachside utilizes the teamwork approach to provide you with a higher quality treatment plan. If you find that you work well with a particular therapist you are more than welcome to request that therapist for your appointments.

After your first treatment your body may be sore. **THIS IS NORMAL.** Your Physical Therapy plan may include exercises that work muscles previously not used before and this may cause slight discomfort. This does not mean you should stop Physical Therapy. Inform your PT about any discomforts you may be having before, during, or after your treatment. They may make recommendations on how to solve these issues including altering our care plan, using ice or heat, or decreasing the exercise load.

### **Insurance: What will they pay? What do I pay? How does it work?**

All insurance plans are different. Some plans may cover your Physical Therapy at 100% and others may require a co-payment from you. On your first visit we will obtain a copy of your insurance card. Our front office staff will call your insurance company to determine what your coverage is. By your second visit\* you will receive an *Explanation of Benefits* (EOB) from our billing department explaining what your insurance company has told us. It will tell you what your insurance company will pay, give you an estimate of what you will have to pay, and any limitations your plan may have with regards to Physical Therapy.

It is important that you know that physical therapy bills differently than a regular doctor visit. Instead of seeing one charge on your insurance carriers EOB, it is possible to see upwards of 4 different charges. This is because we must bill for each procedure that is performed at each visit. And because you will be progressing at each visit, it is likely that we will be doing different procedures at each appointment, giving you a different charge for each visit.

Some insurances have confusing limitations, caps, and restrictions that may be difficult to understand. For these questions you may want to call your insurance company directly or you may call our Account Representative, Patricia Gant, at 321-773-8155.

For those patients who require it, Beachside Physical Therapy offers payment plans. We do this as a service to our patients so that finances do not deter you from obtaining the care that you need. For more information about this plan, please contact Patricia Gant at 321-773-8155.

General Questions? Call our HR Director, Amanda Demers 321-777-4033  
Billing Questions? Call 321-773-8155

**5 Convenient Locations** Indian Harbour Beach 321-773-5290 Indialantic 321-727-2707  
Melbourne 321-255-5500 Palm Bay 321-984-2933 Viera 321-690-6612

**Beachside Physical Therapy New Patient Demographic Sheet**

Patient ID#: \_\_\_\_\_

Clinic#: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_

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

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_-\_\_\_\_-\_\_\_\_ Circle One: MALE FEMALE

Email Address: \_\_\_\_\_ Spouse Name: \_\_\_\_\_

**\*\* Would you like us to text message you with your next appointment time?** Yes \_\_\_\_ No \_\_\_\_

**\*\*\* Would you like us to email you with your next appointment time?** Yes \_\_\_\_ No \_\_\_\_

**\*\*\* Would you like to receive informational mail outs & emails from Beachside Physical Therapy & Beachside Health Studio?** Yes \_\_\_\_ No \_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about Beachside Physical Therapy? Choose One:

Referred by MD	I am a previous patient	Friend	Postcard	Saw the sign	Other:
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**Financial Information** (If the patient is a minor, please complete this information)

Name of Responsible Party: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

**Insurance Information** (The following section must be filled out COMPLETELY.) I hereby instruct the insurance company below to make payment to Beachside Physical Therapy.

**Primary Insurance:** \_\_\_\_\_ Member ID#: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ Member ID#: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

I understand and agree that I am ultimately responsible for the balance of my account for any professional services rendered, regardless of my insurance. I have read all the information above and certify this information is true and correct to the best of my knowledge. I will notify Beachside Physical Therapy of any changes in my status or the above information. I hereby authorize any treatment(s) agreed upon with the Physical Therapist and my referring physician which are deemed medically necessary.

*I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I also authorize Beachside Physical Therapy, Inc. and its staff to call my home and leave messages regarding appointments with my spouse and/or on the answering machine. Furthermore, I authorize the use of facsimile transmission, e-mail transmission, internet transmission, and electronic transmission of my personal health information for the purpose of treatment, payment, and healthcare operations.*

Patient or Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**DETERMINATION OF PRIMARY PAYOR:**

• Have you received **OUT PATIENT THERAPY SERVICES** in the past 12 months?

**PHYSICAL THERAPY** YES NO  
If so, where? \_\_\_\_\_

**OCCUPATIONAL THERAPY** YES NO  
If so, where? \_\_\_\_\_

**SPEECH THERAPY -** YES NO  
Is so, where? \_\_\_\_\_

• Are you currently receiving or plan on receiving any type of **chiropractic care**? YES NO

• Is Medicare your secondary? YES NO

If so, please indicate the type by circling below.

Working Age Beneficiary      End Stage Renal Disease      No Fault Insurance      Black Lung  
PHC or Other Federal      Veteran's Administration      Disabled Beneficiary  
Other: \_\_\_\_\_

• Are you currently receiving, or plan on receiving, any type of home health care including nursing and home health aid? YES NO

• Is this injury due to an automobile accident? YES NO

If "YES", what was the date of the accident? \_\_\_\_\_

Is there an attorney involved? \_\_\_\_\_

• Is this injury work related? YES NO

If "YES", what was the date of injury? \_\_\_\_\_

If "YES", what is the employer name and address? \_\_\_\_\_

• Is your injury the result of any other type of accident? YES NO

If "YES", please provide us with the details: \_\_\_\_\_

I understand that if payment of services by Medicare or other insurance payers is denied due to false information I will be held responsible for these charges.

**Patient or Responsible Party Signature:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_



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## Beachside Physical Therapy, Inc.

### Acknowledgement of Receipt of Notice of Privacy Practices

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have been provided with a **Notice of Privacy Practices** that gives a more complete description of information uses and disclosures as well as a description of my privacy rights. I understand that I can review the notice prior to signing this acknowledgement. I understand that the organization reserves the right to change their notice and practices and will provide me a copy of any revised notice.

Patient Name: \_\_\_\_\_ Print

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Privacy Notice Date: 10/01/14

I give permission to share appointment, billing or medical information with the person(s) named here:

Name:

Relationship:

Name:

Relationship:

# *Beachside Physical Therapy*

Indian Harbour Beach • Indialantic • Melbourne • Viera • Palm Bay

Dear Patient:

During the course of your treatment it is extremely important that you are compliant with all of your scheduled appointments to enhance your recovery and follow the treatment plan prescribed by your physician.

Cancelled appointments severely impact your treatment plan as well they prevent Beachside Physical Therapy from scheduling acutely ill patients who could have been seen that day, but were not because someone else was scheduled for that time spot. No shows also drive up the cost of patient care for everyone as staffing and overhead cost for services go unused.

Due to an increasing problem with patients missing scheduled appointments or “No Shows”; I regrettably must institute a “No Show Policy”. A fee of \$75.00 will be charged to your account for failure to show up for a scheduled appointment, or for cancellations with less than 24 hours notice. This charge is not covered by insurance. We understand emergencies occur therefore rescheduling appointments is possible so please inform the front desk.

It is also important that you arrive on time for scheduled appointments to ensure the quality of your care as well as the quality of care for patients who do arrive on time for their appointments.

Patient care is of the utmost importance to the staff of Beachside Physical Therapy as evidenced by our past successes. We look forward to serving your needs and please let us know if there is anything we can do to help!

Sincerely,

Scott Schroeder  
President

Patient or responsible party signature \_\_\_\_\_

Printed Name \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient ID #: \_\_\_\_\_

### MEDICAL HISTORY

Allergies	<input type="radio"/> Yes <input type="radio"/> No	Dizzy Spells	<input type="radio"/> Yes <input type="radio"/> No	MRSA	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Emphysema/Bronchitis	<input type="radio"/> Yes <input type="radio"/> No	Multiple Sclerosis	<input type="radio"/> Yes <input type="radio"/> No
Anxiety	<input type="radio"/> Yes <input type="radio"/> No	Fibromyalgia	<input type="radio"/> Yes <input type="radio"/> No	Muscular Disease	<input type="radio"/> Yes <input type="radio"/> No
Arthritis	<input type="radio"/> Yes <input type="radio"/> No	Fractures	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Gallbladder Problems	<input type="radio"/> Yes <input type="radio"/> No	Parkinsons	<input type="radio"/> Yes <input type="radio"/> No
Autoimmune Disorder	<input type="radio"/> Yes <input type="radio"/> No	Headaches	<input type="radio"/> Yes <input type="radio"/> No	Rheumatoid Arthritis	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Hearing Impairment	<input type="radio"/> Yes <input type="radio"/> No	Seizures	<input type="radio"/> Yes <input type="radio"/> No
Cardiac Conditions	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis	<input type="radio"/> Yes <input type="radio"/> No	Smoking	<input type="radio"/> Yes <input type="radio"/> No
Cardiac Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Speech Problems	<input type="radio"/> Yes <input type="radio"/> No
Chemical Dependency	<input type="radio"/> Yes <input type="radio"/> No	High/Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Strokes	<input type="radio"/> Yes <input type="radio"/> No
Circulation Problems	<input type="radio"/> Yes <input type="radio"/> No	HIV/AIDS	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Currently Pregnant	<input type="radio"/> Yes <input type="radio"/> No	Incontinence	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Depression	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Vision Problems	<input type="radio"/> Yes <input type="radio"/> No
Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Metal Implants	<input type="radio"/> Yes <input type="radio"/> No	Height _____	
				Weight _____	

Describe any other conditions or precautions:

### Fall History

Injury as a result of a fall in the past year? <input type="radio"/> Yes <input type="radio"/> No	Date of Fall: _____
Two or more falls in the last year? <input type="radio"/> Yes <input type="radio"/> No	Dates of Falls: _____

### \*\*\*\* Surgical History

Body Region: _____	Surgery Type: _____	Date of Surgery: _____ / _____ Month / Year
Body Region: _____	Surgery Type: _____	Date of Surgery: _____ / _____ Month / Year
Body Region: _____	Surgery Type: _____	Date of Surgery: _____ / _____ Month / Year

### \*\*\*\* Current Medications I do not take any medications See attached list of medications

Drug: _____	Dosage: _____	Reason for Taking: _____
Drug: _____	Dosage: _____	Reason for Taking: _____
Drug: _____	Dosage: _____	Reason for Taking: _____
Drug: _____	Dosage: _____	Reason for Taking: _____

Patient or responsible party signature \_\_\_\_\_ Date: \_\_\_\_\_

Therapist (print) \_\_\_\_\_ Therapist (signature) \_\_\_\_\_