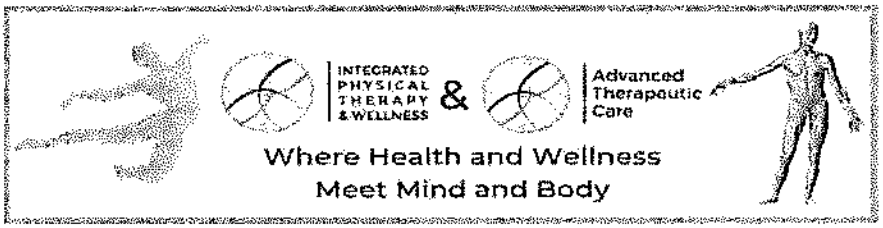



Appt date and Time:_____

**Patient's Name:** _____ **Male/Female D.O.B.:** _____

**Address:** _____

**City:** _____ **State:** _____ **Zip Code:** _____

**Home Phone #:** _____ **Cell #:** _____

**E-mail Address:** _____

**Height:** _____ **Weight:** _____ **Referring Physician:** _____

**Diagnosis:** _____ **RX Date:** _____

**Is This Injury Due to:** Work /Auto Acc. / Litigation? **Y /N** **Have You Had Therapy This Year: Y/N**
**Have you had any Home Health Services in the past 30 days? Y/ N**

**How do you hear about us: Dr. Referral – Friend Referral – Magazine – Other** _____

**Name of Insurance**_____ **Insurance Phone #**_____

**ID #**_____ **Group #** _____

**Primary Insured Name:** _____ **Primary Insured D.O.B. :** _____

**Secondary Insurance Information**

**Name of Insurance**_____ **Insurance Phone #** _____

**ID #**_____ **Group #**_____

**Assignment - Release - Obligations**

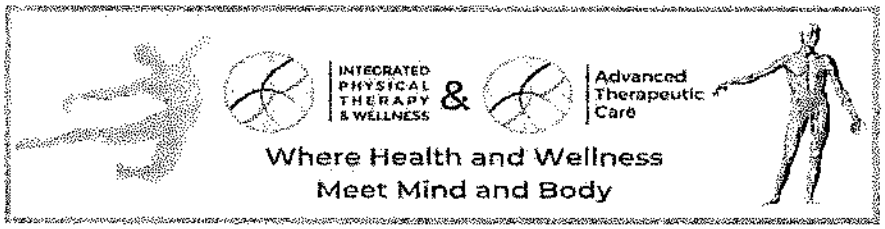
I, the undersigned, certify that I (or my dependent) has insurance as stated above and assign directly to Centerline Physical Therapy/CPT (DBA: Advanced Therapeutic Care/ATC) & Integrated Physical Therapy/IPT all insurance benefits.

- I understand that I am financially responsible for all charges whether paid by insurance or not.
- I understand that I am financially responsible for all co-insurance, co-pays, or self-pay pricing.
  - at the time of service.
- I hereby authorize release of all information necessary to secure the payment of benefits.
- I authorize the use of this signature for all insurance submissions and/or to release medical records to primary physician and/or health insurance company.
- I consent to the treatment necessary for the care of the above-named patient/client including manual hands-on therapies, exercise programs, modalities and any other therapies needed during your care.

_____

Responsible Party's Signature Relationship Date

2146 NE 123rd Street North Miami, FL 33181
1000 South Dixie Highway Hallandale, Fl 33009
305 967-8976 - 954 458-5700 - @IPTmiami – IPTmiami.com



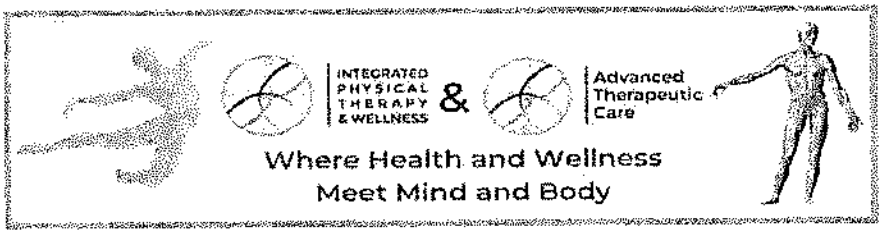

# Our Pledge Regarding Medical Information:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at CPT. We need this record to provide you with quality care and to comply with legal requirements. This notice applies to all of the records of your care generated by CPT. We are required by law to:

a. Make sure that medical information that identifies you is kept private.
b. Give you this notice of our legal duties and privacy practices with respect to medical information about you.

**Have you ever had the following?**

| | | | |
|---|---|---|---|
| Yes / No | Increased Blood Pressure | Yes / No | Increased Cholesterol |
| Yes / No | Heart Conditions | Yes / No | Depression |
| Yes / No | Lung or Respiratory Disorder | Yes / No | Anxiety Disorders |
| Yes / No | Arthritis | Yes / No | Circulation Disorders |
| Yes / No | Chronic Fatigue | Yes / No | Dizzy Spells or Light Headedness |
| Yes / No | Pacemaker | Yes / No | Diabetes - Type I or II |
| Yes / No | Stroke / CVA | Yes / No | Cancer _____ |
| Yes / No | Incontinence | Yes / No | Are You Pregnant |
| Yes / No | Concussion or TBI | Yes / No | Pain With Intercourse |
| Yes / No | Spinal Injury | Yes / No | Gynecological Disorder |
| Yes / No | History of Falls | Yes / No | Tobacco Use |
| Yes / No | Headaches | Yes / No | Neurological Disorders |




**Please list any and all medications you are currently taking:**

| Medication Name | Dose | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Please list any prior medical history you feel is important for us to know: _____

_____

_____

_____

Scar tissue can cause pain and dysfunction in the body. Please list all surgeries you have had, including cosmetic. _____

_____

What, if any, recent diagnostic studies have you had? (MRI, Doppler, X-ray, etc)

_____

History of current condition, including onset date.

_____

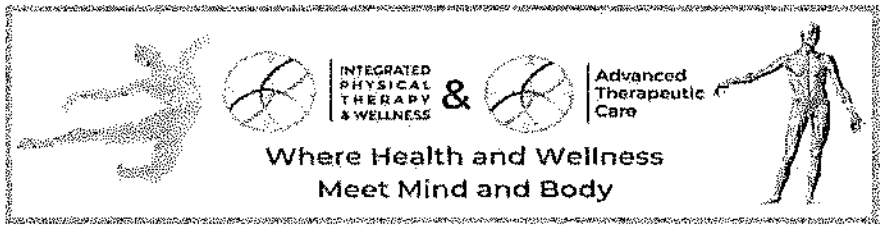
_____

_____

Patient Signature/Guardian_____ Date: _____

If a Patient/Client is under 18 years of age, and a parent is not available to attend sessions of Physical Therapy with the minor, the Parent(s) signature for authorization allows Physical Therapy or fitness treatments with the patient who is a minor.

2146 NE 123rd Street North Miami, FL 33181
1000 South Dixie Highway Hallandale, Fl 33009
305 967-8976 - 954 458-5700 - @IPTmiami – IPTmiami.com




**Payment options:**

- Zelle, Venmo, Cash or Check (There is a $35.00 fee for all returned checks)

**Billing:**

- Payment is expected when services are rendered.
- The patient is responsible for all charges for services provided.
- If using your insurance/Medicare, CPT will file all claims on your behalf
    - If you are a self-pay patient – we **WILL NOT** submit your claims

**Cancelled/Missed Appointments:**

- Late arrivals are subject to the full fee for the session.
- **We require 24 hours' notice for all cancellations.**
- **Insurance clients:** All appointments that are cancelled within less than 24 hours' notice or "no-show" are subject to the full fee for the session. With 2 missed appointments, either cancelation or no-show, CPT reserves the right to cancel all remaining appointments. **$50.00 fee will be charged** for cancellations within less than 24 hours' notice.

**Medicare:**

- Patient is responsible for any deductible remaining at the time of service, unless you have a secondary insurance that covers the deductible
- *Please be aware, there is a cap/maximum allowable amount for Medicare claims*

**Self-Pay Patients:**

- We require 24 hours' notice for all cancellations.
- All cancelations with less than 24 hours' notice or "no-show" are subject to the **full fee**

**Ongoing Education:**

- We believe in continued education experiences for our community and our facility participates with accredited Physical Therapy programs accepting students for observation and clinical advancement of their schooling.
- Photo/Video Release: I hereby give permission to take and use photos/videos for education and social purposes.

I have read and agree with the above and understand that the client/patient is ultimately responsible for all charges for services provided/rendered.

_____ _____

Patient Signature Date

2146 NE 123rd Street North Miami, FL 33181
1000 South Dixie Highway Hallandale, Fl 33009
305 967-8976 - 954 458-5700 - @IPTmiami – IPTmiami.com