ON THE HOP ORTHO, SPORTS & AQUATIC THERAPY
7171 N. University Drive, Suite 111
Tamarac, FL 33321
Phone: (954) 722-9992 Fax: (954) 597-7773

Welcome To Our Office!

Patient Name: _____ Nickname/preferred name (if any):_____

Date of Birth: _____ Age:_____ Height:_____ Weight:_____

Home Address:_____

Secondary Address (if any):_____

Home Phone #:_____ Mobile/Cell Phone#:_____

Email Address:_____

Social History: (circle all that apply)

*Single *Married *Divorced *Widowed *Lives Alone *Lives w/other *Independent living facility *Assisted living

*Unemployed *Employed *Retired _____Current /former Occupation

Hobbies/activities:_____

Exercise: type(s):_____ frequency:_____

Patient Signature:_____ Patient Printed Name:_____ Date:_____

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Patient Name:_____ Referring MD:_____

Chief Complaint:_____

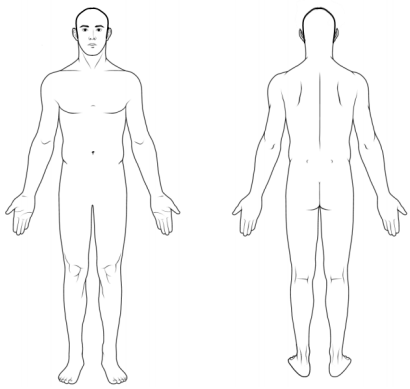
Why are you being seen today?_____

Type of Injury: ___None ____sports ___slip and fall ___auto accident ___work related accident ___other(explain)

How long have you had this problem:_____ When did it become severe:_____

Location of pain:

Right Left Left Right



Description of pain: ___Occasionally ___Constant ___Daily ___

___worse w/motion ___wakes from sleep ___ worse in morning ___night

___sharp pain ___dull ache ___throbbing ___burning ___stabbing

___radiating pain ___vague

Rate your pain level: 0 (no pain) – 10 (worst pain imaginable) :

Current: ____/10 at rest: ____/10 at worse: _____/10

Functional Limitations:

Difficulty: ___sitting ___rising from sitting ___standing ___walking ___ sleeping on side ___ raising arm

___putting on shoes/socks ___ light – moderate lifting ___personal hygiene ___climbing stairs ___negotiating curbs

___getting in/out of car or bed ___performing usual physical activities (be specific; ie golf, gardening, knitting etc…)

Do you use a cane or walker? _____ If so, for how long?_____

Has your leg given out? Or have you fallen?_____ If yes, when? _____ Did you need assistance to get up? ____

Did fall(s) require medical attention, surgery or hospitalization? _____ Can you walk more than one block?_____

Does the pain/disability limit your ability to perform your activities of daily living? _____

Patient Signature:_____ Date: _____

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Patient Name:_____

Past Medical History: (circle all that apply) *None

*Asthma *Sleep Apnea *Blood Clot * High Blood Pressure *Diabetes *Lung Disease –COPD *Ulcers *Diverticulitis

*Heart Disease *Stroke *Hepatitis *Nerve Disease/Neuropathy *Kidney disease * Gout *HIV/AIDS

*Arthritis *Rheumatoid Arthritis *Fibromyalgia *Osteoporosis *Osteopenia * Fractures :_____

*Cancer (type)_____ Other:_____

Past Surgical History: (circle all that apply) *None

*Appendectomy *Gall Bladder *Hernia *Stomach/Colon *Cataracts *Heart Bypass/Stents *Pacemaker

*Neck/Back *Shoulder/hand * Hip *Knee *Ankle/foot *Joint Replacement (Location):_____

General Review : Check/ Circle all that apply

*Fever *Chills *Weight Loss *Weight Gain *Nausea *Dizziness * Visual Impairment *Hearing Loss *Vertigo

*Shortness of Breath *Anxiety *Depression *Fatigue *Insomnia *Headaches *Memory loss * Incontinence

*Swelling *Bleeding *Numbness/tingling *Skin Lesions/Rash *frequent falls *Allergies:_____

*Other_____

Please list current medications/dosage:

_____
_____
_____
_____

Patient Signature:_____ Date:_____

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*Unemployed *Employed *Retired _____Current /former Occupation

Home – environment:

do you have stairs at home/work? _____

do you have a walk-in shower? ____ bath tub? _____ Do you have safety bars in place? ____

Hobbies/activities:_____

Exercise: type(s)_____ Frequency:_____

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FORMS, LETTERS AND MEDICAL RECORDS FEES

The following are office charges for processing requests for form completion, letters and copies of medical records.

Payment is due prior to services being rendered.

$25.00 charge for :

Disability Insurance forms

Sickness/Accident Insurance forms

FMLA forms

Medical Records / X rays:

$1.00 per page for the first 25 pages

$0.25 for ea additional page

$10.00 for copies of X-rays (digital, on CD)

Initials _____

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INSURANCE AND PAYMENT POLICIES

YOU ARE RESPONSIBLE FOR YOUR INSURANCE POLICY

Your insurance policy is a contract between you and your insurance company and its terms define your rights and responsibilities. Due to the hundreds of policies available and the many changes in insurance plans, we cannot be responsible for knowing and interpreting each individual policy. It is your responsibility to know your coverage, its limitations and whether or not the medical services/provider is a participant for your specific plan. We urge you to check with your insurance company regarding your benefits. Failure to do so could result in you or the financially responsible party being responsible for all costs incurred in treatment.

NON-PARTICIPATING PROVIDER POLICY

If On the Hop Therapy is not a participating provider for your insurance plan and you choose to be treated here, we will collect fees in full at the time of service.

YOUR FINANCIAL RESPONSIBILITY

You are responsible for payment of any co-payments, co-insurance, deductibles, etc. at time of service as specified by the terms of your insurance plan.

Our office will file insurance claims for all reimbursable services to both your primary and secondary carriers. All deductibles and co-pays are collected at the time of service. Any other amounts due will be billed monthly. If your account becomes delinquent, it may be referred to a collection agency and you will be assessed a 35% agency fee and any costs of litigation incurred in collecting your delinquent account. Checks returned with NSF, will be assessed bank charge of $35.

Patient signature:_____ Date:_____

Print patient name:_____

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Policy for "No Show" appointments

We work hard to respect patients' wishes to get appointments as quickly as possible and to make them at times that are most convenient. In order to do this, we in turn, ask patients to be mindful of the fact that there are a limited number of patients our medical providers can see in a day. When someone fails to show for an appointment without notifying us in advance, another patient has lost the opportunity to be seen at that time, and we have lost the ability to render our services to someone in need.

We find that most patients keep their appointments and notify us in advance when they must reschedule or cancel. There are other cases, however, called "no shows" ; patients who REPEATEDLY fail to come in for appointments and do not let us know ahead of time they will not be coming. In these cases we have instituted a policy of charging for "no shows". The charge is billed to patients directly as insurance policies do not cover charges of this nature.

Because we understand that in life there are sometimes unforeseen circumstances that may prevent a patient from keeping an appointment, the first time a "no show" occurs, we will take note of it, but there will be no charge. If, however, the patient fails to show for additional appointments, a $25.00 charge will be assessed. Patient will be responsible for payment before another appointment is made.

Being able to respect your needs for timely and convenient appointments is very important to us and for that reason we provide the courtesy of appointment confirmations by way of calls and/or email messages. Whether or not we are able to speak with patients personally or deliver messages to confirm existing appointments, we expect patients to keep track of appointments made and to keep them, barring urgent and /or unforeseen circumstances. We thank you for understanding the need for us to have a policy of this nature.

Patient name:_____ Date:_____

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ASK ABOUT PRIVATE PAY FOR YOUR PHYSICAL THERAPY/REHABILITATION

ASK ABOUT MASSAGE THERAPY

ASK ABOUT AQUATIC THERAPY

We offer competitive rates for our patients/clients that may want to receive physical therapy services in our facility.

***Single/individual sessions available**

***Packages for multiple sessions available**

See front desk for details

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FAX:

To:	**From:** Physical Therapy Dept
Fax:	**Pages:**
Phone:	**Date:**
Re:	

Comments:

Please review the initial evaluation and plan of care performed on your patient,

_____.

Please sign and return the Plan of Care, along with any additional instructions, if any, at your earliest convenience.

Thank you,

Joette Lloyd, PT

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PAYMENT SCHEDULE FOR SELF PAY PATIENTS :

1 SESSION: $75.00 per visit

5 SESSIONS: $65.00 per visit (pre-paid packages of 5)

10+ SESSIONS: $60.00 per visit (pre-paid packages of 10)

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JOIN US FOR…

SATURDAY MORNING – BOOT CAMP – FITNESS CLASS

HIGH SCHOOL – COLLEGE ATHLETE – WEEKEND WARRIOR

Beginning Jan.12, 2020

1 hour class - $25.00/ea

5 class package – 20.00 per class ($100.00)

*minimum 4 participants must be registered by 9am on Friday before

*schedule may be subject to change or cancellation depending on participation.