



“because the more you know, the better you feel”

Welcome Sir or Madam:

Thank you for choosing Smart Body Physical Therapy for your neuromuscular and/or musculoskeletal needs. We are committed to helping you achieve your rehabilitation goals in the most effective and efficient manner possible. In order to achieve these goals, we need your assistance:

**Your Feedback:** We believe it is essential you take an active role in your therapy, which includes giving us candid feedback on how effective your treatment is and how compliant you have been with your home exercises. If you have questions about your progress or have suggestions, please do not hesitate to discuss these concerns with your therapist. We value your feedback.

**Designated Treatment Area:** In order to respect patient confidentiality, in addition to safety precautions, we request that visitors, spouses, and other family members remain in the waiting area, unless the patient’s therapist requests their presence. Our patients deserve our undivided attention.

**Adult Supervision:** Minors, those under the age of 18, receiving treatment at our facility must be accompanied by a parent or legal guardian during each physical therapy appointment.

**Children:** Please refrain from bringing children into the treatment area to ensure you have our full attention. Children under the age of 12 should not be left in the waiting area without adult supervision.

**Appointments:** We see patients by appointment only. Please call ahead if you think you will be late. We reserve the right to reschedule your appointment if you are more than 15 minutes late to your appointment.

**Cancellations:** A \$30 fee will apply for each appointment that is cancelled with less than 24 hours notice. You may leave a message on voicemail if you are calling after hours. If you miss two consecutive scheduled appointments without prior notification, your remaining appointments will be removed from our schedule. In order to return to therapy, you will need to call to reschedule your next appointment.

**Courtesy:** In consideration of our patients with breathing difficulties, please refrain from wearing heavy perfumes/colognes while in physical therapy.

**Payment:** Please provide co-payment on the day services are rendered. We accept cash, check, MasterCard and Visa.

**Billing:** You agree that any dispute or claim (including personal injury claims) related to health care services that you receive from staff at Smart Body in Jacksonville, FL that is not resolved by mutual agreement is subject to the exclusive jurisdiction of the appropriate court in Florida under Florida law.

This agreement also applies to anyone claiming on your behalf. If you believe your bill is incorrect please contact our billing department immediately and we will do our best to resolve any concerns you may have.

Thank you for your attention regarding these matters.

Sincerely,

Laura Bunso Bittencourt, P.T., M.T.C.  
Clinical Director

**I HAVE READ, UNDERSTOOD AND AGREED TO THE ABOVE REQUESTS.**

_____	_____
Signature of Patient or Guardian	Date



"because the more you know, the better you feel"

PATIENT INFORMATION

Patient: \_\_\_\_\_ Social Security: \_\_\_\_\_
(Last) (First) (MI)

Date of Birth: \_\_\_\_\_ Address: \_\_\_\_\_
(Street #) (City) (State) (Zip Code)

Home Tel#: \_\_\_\_\_ Work Tel#: \_\_\_\_\_ Mobile Tel#: \_\_\_\_\_ Marital Status \_\_\_\_\_
(S M D W Sep)

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Tel#: \_\_\_\_\_

How did you Hear about us?
Friend Magazine Community Lecture
Relative Internet Other Source

I would like to receive my home exercise program via email
I would like to receive the Smart Body Physical Therapy monthly newsletter

Email Address: \_\_\_\_\_
Referring Physician: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

INSURANCE INFORMATION

Spouse's name or other responsible party: \_\_\_\_\_ Telephone#: \_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_
Subscriber: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_
Self Spouse Parent

PLEASE BE ADVISED THAT PATIENTS WHO DO NOT PROVIDE SECONDARY INSURANCE WILL BE RESPONSIBLE FOR ACCOUNT BALANCE.

Secondary Insurance Company: \_\_\_\_\_
Subscriber: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_
Self Spouse Parent

Are you currently receiving Physical Therapy from another provider? Yes No Who?

Are you seeking Physical Therapy due to a: Motor Vehicle Accident? Work Related Injury? Yes No

If Yes, please complete the following section:
Type of Accident: \_\_\_\_\_ Date of Accident: \_\_\_\_\_ State: \_\_\_\_\_

Claim/Case #: \_\_\_\_\_ Adjustor Name: \_\_\_\_\_

Auto/Work Comp Insurance Co: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Claims Address: \_\_\_\_\_

Attorney Name (if applicable): \_\_\_\_\_ Telephone Number: \_\_\_\_\_

For the services rendered and current services rendered, I hereby assign Smart Body Physical Therapy, any and all medical and/or Physical Therapy benefits otherwise payable to me under the above described policy not to exceed the charges for such treatment. I understand that I am directly and primarily responsible to Smart Body Physical Therapy for their customary fee for the services rendered to me. I realize that if my insurance company fails to pay or if there is any delay in paying Smart Body Physical Therapy, it is my responsibility to pay my medical bill directly. I further understand and agree if I fail to make timely payments to Smart Body Physical Therapy, that I will be responsible for any and all reasonable cost of collection including filing fees as well as any reasonable attorney's fee(s).

I hereby authorize Smart Body Physical Therapy to release to my insurance company any information acquired, including the diagnosis and records in the course of my treatment.

It is understood that Smart Body Physical Therapy assumes no responsibility for personal property such as glasses, dentures, clothing, jewelry, or any other personal items.

I agree to hold Smart Body Physical Therapy harmless from any and all costs, liability and damages of and nature whatsoever, including reasonable attorney's fees, resulting directly from the release of my medical records pursuant to this consent.

I ACKNOWLEDGE THAT I HAVE READ THIS AUTHORIZATION AND FULLY UNDERSTAND ITS CONTENTS.

Signature of Patient or Guardian \_\_\_\_\_ Date \_\_\_\_\_

Patient Name: \_\_\_\_\_ MR # \_\_\_\_\_ SMART BODY PHYSICAL THERAPY AGREEMENT

**AUTHORIZATION FOR TREATMENT**

Initials

I hereby consent and authorize the performance of all appropriate procedures and courses of treatment, which in the judgment of my provider may be considered necessary or advisable for my diagnosis and/or treatment. I have a condition requiring physical therapy care, and hereby consent to the rendering of such care, which may include such medical treatment as my attending physician(s) or other Smart Body Physical Therapy staff consider necessary. I understand that my medical care and treatment may be provided by a physical therapist, physical therapist assistant or physical therapy doctoral intern.

**RESPONSIBILITY TO PROVIDE PROOF OF INSURANCE AND OBTAIN REFERRAL**

Initials

I understand that it is **my responsibility** to provide Smart Body Physical Therapy with a copy of my **current insurance card(s)** and to **obtain a referral** from my Primary Care Physician (if required by my insurance or past the 21st day Florida law). If I do not have insurance, I will be considered a Private Pay (or Self Pay) patient and I am financially responsible for the total amount of the services provided. **I will notify Smart Body Physical Therapy immediately upon any changes in my insurance.**

**INSURANCE WAIVER and NON-COVERED SERVICES WAIVER**

Initials

I understand that if I do not have a copy of a current insurance card and valid referral, if required, Smart Body Physical Therapy is not obligated to see me, but if I still wish to be seen, I can be seen as a "Private Pay" patient. I agree that neither Smart Body Physical Therapy nor I will file a claim for the visit. I will be required to pay the total cost of the visit in advance.

In addition, there may be a service I desire, suggested or provided that is not covered under my insurance plan; I understand I must pay for "Non-Covered" services. If feasible, a waiver will be completed for each "Private Pay" visit or "Non-Covered Services."

**PRIVACY NOTICE ACKNOWLEDGEMENT**

Initials

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I hereby acknowledge that I have had the opportunity to review a copy of Smart Body's "Notice of Privacy Practices". I understand that I am responsible to read this Notice and notify Smart Body Physical Therapy, in writing, of any request for restrictions in the use or disclosure of my individually identifiable health information. Smart Body Physical Therapy has the right to revise this Notice at anytime and will post a copy of the current Notice in the office in a visible location at all times and on their website at [www.smartbodypt.com](http://www.smartbodypt.com). I am aware that Smart Body has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information it maintains. Smart Body Physical Therapy will provide me with a copy of its most recent Notice upon my request.

**ASSIGNMENT OF BENEFITS**

Initials

I hereby authorize and assign all payments and/or insurance benefits for medical services rendered to the patient, directly to Smart Body Physical Therapy. I hereby authorize Smart Body Physical Therapy to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by my insurance plan.

**ATTIRE**

Initials

For access to particular body parts being treated, loose fitting clothing is recommended.

If your evaluation includes a diagnosis that involves an assessment of the pelvis and/or pelvic floor muscles, this may require you to change clothing and wear a gown. An example of this might be evaluation and treatment for the diagnosis of urinary incontinence or leakage.

**ADDITIONAL INFORMATION**

Initials

Smart Body Physical Therapy accepts payments in: Cash, Check, Visa and MasterCard.

I understand additional charges are applied to my account for any returned checks used to pay on my account, for certified letters sent to me for collection on my account and collection agency fees. I may also be charged for educational materials and for other administrative expenses, including copies of medical records, not covered by my insurance plan. I understand that if I do not cancel my scheduled appointment 24 hours in advance that I will incur a \$30.00 cancellation fee.

**BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.**

Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employee's signature who reviewed intake of form: \_\_\_\_\_ Date: \_\_\_\_\_



*Orthopedics | Sports Medicine | Women's & Men's Health | Manual Therapy | Custom Orthotics*

6639 Southpoint Parkway | Suite #103 | Jacksonville, FL 32216

Phone: (904) 296-4140 Fax: (904) 279-0963

**Authorization to Release Medical Records**

I, \_\_\_\_\_, give permission to Smart Body Physical Therapy to release my medical records to:

**Spouse or other Family Member**

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

Mailing Address: \_\_\_\_\_

Fax # \_\_\_\_\_ Telephone # \_\_\_\_\_

**Physician or other Health Care Providers:**

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

Mailing Address: \_\_\_\_\_

Fax #: \_\_\_\_\_ Telephone #: \_\_\_\_\_

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

Mailing Address: \_\_\_\_\_

Fax #: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Please release the following information:

Physical Therapy Evaluation & Plan of Care

Daily Notes (From: \_\_\_\_\_; To: \_\_\_\_\_)

Billing Records (From: \_\_\_\_\_; To: \_\_\_\_\_)

Other Information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If you have any questions for Smart Body Physical Therapy, please call (904) 296-4140.

\_\_\_\_\_  
Patient Signature Date

\_\_\_\_\_  
Witness Signature Date

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_ Marital status \_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_ Date \_\_\_\_\_

Describe the problem(s) for which you seek Physical Therapy. (You can continue on back of this sheet of paper for more space to write.)

\_\_\_\_\_ Rate your pain level. Current \_\_\_\_\_ /10; Best \_\_\_\_\_ /10; Worst \_\_\_\_\_ /10

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

When did the problem(s) begin? Have you ever had the problem(s) before? If yes, what did you do for the problem(s)?

What makes your symptoms better?

What make your symptoms worse?

What are your goals for Physical Therapy? Or what was your prior level of function?

**Do you take any prescription medications?**  No  Yes  
If yes, please list or attach your list: \_\_\_\_\_

**Do you take any non-prescription medications?**

(Check all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> Advil/Aleve        | <input type="checkbox"/> Decongestants      |
| <input type="checkbox"/> Antacids           | <input type="checkbox"/> Herbal Supplements |
| <input type="checkbox"/> Ibuprofen/Naproxen | <input type="checkbox"/> Tylenol            |
| <input type="checkbox"/> Antihistamines     | <input type="checkbox"/> Other: _____       |
| <input type="checkbox"/> Aspirin            |   |

**Are you seeing anyone else for the problem(s)?**

(Check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> Acupuncturist                             | <input type="checkbox"/> Occupational Therapist |
| <input type="checkbox"/> Cardiologist                              | <input type="checkbox"/> Orthopedist            |
| <input type="checkbox"/> Chiropractor                              | <input type="checkbox"/> Osteopath              |
| <input type="checkbox"/> Dentist                                   | <input type="checkbox"/> Pediatrician           |
| <input type="checkbox"/> Internist                                 | <input type="checkbox"/> Podiatrist             |
| <input type="checkbox"/> Massage Therapist                         | <input type="checkbox"/> Primary Care Physician |
| <input type="checkbox"/> Neurologist                               | <input type="checkbox"/> Rheumatologist         |
| <input type="checkbox"/> Obstetrician/Gynecologist                 | <input type="checkbox"/> Other(s) _____         |
| <input type="checkbox"/> Prior Physical Therapy, if so when? _____ |   |

**Please rate your health.**

- Excellent  Good  Fair  Poor

**Do you exercise beyond normal daily activities and chores?**

- No  Yes, \_\_\_\_\_ minutes/day x \_\_\_\_\_ days/week

Describe the exercise \_\_\_\_\_

**Do you currently smoke tobacco?**  No  Yes, \_\_\_\_\_ packs/day

If you smoked in the past, what year did you quit tobacco? \_\_\_\_\_

**How often do you drink alcoholic beverages?** \_\_\_\_\_ drinks/week

**Hand dominance.**  Right handed  Left handed

**Assistive devices.**  Cane  Walker  Rollator  Orthotic

Wheelchair  other \_\_\_\_\_

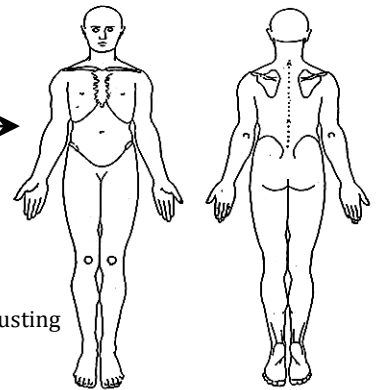
Please indicate on the body diagram where your pain(s) is.

**Please describe your pain.**

(Check all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> Throbbing       | <input type="checkbox"/> Aching            |
| <input type="checkbox"/> Shooting        | <input type="checkbox"/> Heavy             |
| <input type="checkbox"/> Stabbing        | <input type="checkbox"/> Tender            |
| <input type="checkbox"/> Sharp           | <input type="checkbox"/> Splitting         |
| <input type="checkbox"/> Cramping        | <input type="checkbox"/> Tiring-exhausting |
| <input type="checkbox"/> Gnawing         | <input type="checkbox"/> Sickening         |
| <input type="checkbox"/> Hot-burning     | <input type="checkbox"/> Fearful           |
| <input type="checkbox"/> Punishing-cruel | <input type="checkbox"/> Other _____       |

(Adapted from Short-form McGill Questionnaire)



**Any customs, beliefs or wishes that might affect care?**

**Language.**  English understood  Interpreter needed for

Language \_\_\_\_\_

**Where do you live?**

- House  Apartment  Assisted living facility  
 Homeless  Nursing home  Other \_\_\_\_\_

**With whom do you live?**

- Alone  Child/Children  Spouse/Significant other  
 Group  Attendant  Other \_\_\_\_\_

**Does your home have the following?** (Check all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> Stairs, no railing | <input type="checkbox"/> Uneven terrain |
| <input type="checkbox"/> Stairs, railing    | <input type="checkbox"/> Bathtub        |
| <input type="checkbox"/> Ramps              | <input type="checkbox"/> Shower         |
| <input type="checkbox"/> Elevator           | <input type="checkbox"/> Pets           |
| <input type="checkbox"/> Other _____        |   |

**Do you have any learning barriers?**  Vision  Hearing

Reading  Other \_\_\_\_\_

**What is your learning style?**  Pictures  Reading  Listening

Demonstration  other \_\_\_\_\_

MR# \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_



PHYSICAL THERAPY INITIAL EVALUATION
Patient Medical History Form

First name MI Last Date Referring Physician

Do you have a history of any of the following? And indicate which member of your family has the following diseases.(Indicate age of onset) (Check all that apply)

- Checkboxes for various medical conditions: Allergies, Heart valve replacement, Osteoporosis, etc.

Within the past year, have you had any of the following symptoms? (Check all that apply)

- Checkboxes for symptoms: Chest pain, Loss of appetite, Nausea/vomiting, etc.

For men only.

- Checkboxes for men's health: Prostate disease, Endometriosis, Menopause, etc.

Please list all surgical procedures you have had.

Table with columns: Year, Procedure, Surgeon

Within the past year, have you had any of the following tests? (Check all that apply) And write any significant findings in space provided.

- Checkboxes for various tests: Angiogram, Arthroscopy, Biopsy, Mammogram, MRI, Myelogram, etc.

MR# Reviewed by: Date: