David Stevenson Physical Therapy, Inc Patient Intake Information

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Name:____
(Last) (First) (M.I.)

Local:____
(Street) (City) (State) (Zip Code)

Out of State Address: ____

Home Phone (   ) _______________ Cell (   ) _______________ Work (   ) ______________

Social Security # ________________________ Date of Birth: _____________________ Age: ________

Occupation: __________________________ Employer: ______________________________________

Marital Status: _______________ Spouse's Name: ____

Emergency Contact: ____________________ Phone #: _______________ Relationship: __________

Referring Physician: ________________________ Family Physician: ___________________________

Date of Injury: ________ How did injury occur? _____________________ Date of Surgery: ________

Have you had physical therapy for this injury before? _______________________________________

Is your injury related to a Workman's Compensation Claim?	☐ Yes	☐ No
Is your injury motor vehicle related?	☐ Yes	☐ No
Have you had ***any*** home health services in the last 60 days?	☐ Yes	☐ No
Have you received ***any*** previous therapy this year?	☐ Yes	☐ No

PATIENT CONSENT TO RECEIVE EMAIL, MAIL AND /OR TELEPHONE MESSAGES

DO WE HAVE PERMISSION TO CALL OR EMAIL YOU? ☐ Yes ☐ No

Call you at home? ☐ Yes ☐ No Leave a message? ☐ Yes ☐ No
Call you at work? ☐ Yes ☐ No Leave a message? ☐ Yes ☐ No

Email Address ____

Share appointment information or billing information with another person in your home?

☐ Yes ☐ No ** If yes, Name _________________________ Relationship__________________

Patient Name ____ DOB:________________ Date of Eval: ________________

Height:__________ Weight:__________ Hand Dominance: _____Right _____Left

Briefly describe the current problem(s) that brought you here:

____

When did your symptoms begin? ____

Are your symptoms: _______Improving _______Getting Worse _______Staying the Same

Have you had any testing? _______ X-rays _______MRI _______EMG/Nerve conduction test _______ CT Scan

Results:____

Have you had these symptoms before? _______Yes _______No

Have you had treatment before for these symptoms? _______Yes _______No

If yes, what has helped in the past?____

Date of next doctor appointment: ____

Are you currently receiving home health care? _______Yes _______No

If you have pain, what is your pain level?

*(0= No pain, 10=Extreme pain- **Please Circle**)*

At Worst: 0 1 2 3 4 5 6 7 8 9 10

At Best: 0 1 2 3 4 5 6 7 8 9 10

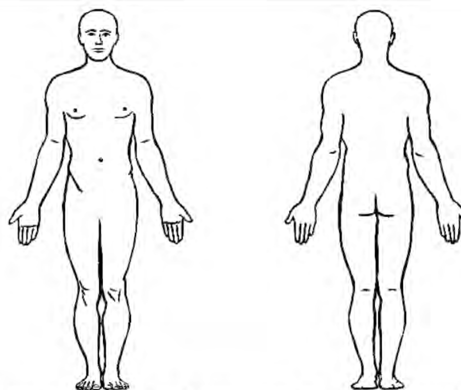
Are your symptoms: _____Constant _____Come and Go

_____Deep _____Sharp _____Shooting _____Numbness/Tingling

_____Burning ______Dull/Ache _____Other

What makes your pain better? ____________________________

What makes your pain worse?____________________________



Mark on figure above your areas of pain and symptoms with an "X"

Previous/Current Medical History:

Please check ***ALL*** that apply

- ☐ Allergies
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Night Pain
- ☐ Heart Disease
- ☐ Pacemaker
- ☐ Cancer
- ☐ Osteoporosis/Osteopenia
- ☐ Bowel/Bladder Problems
- ☐ Fibromyalgia
- ☐ Smoking History
- ☐ High/Low Blood Pressure
- ☐ Diabetes I or II
- ☐ Neurological Problems
- ☐ Circulation Problems
- ☐ Unexplained weight loss/gain
- ☐ Other ____________________
- ☐ Surgery (please list/describe)

____

____

Have you had any falls in the last 12 months? _____Yes _____No

If yes, please describe the nature of the fall: ____

If yes, please describe if an injury(ies) occurred: ____

Are you currently using an assistive devices? _____Yes _____No If yes, what assistive device? __________________

Do you have difficulty with any of the following activities?

______Walking ______Bathing ______Feeding ______Dressing/Grooming ______Toileting ______Transferring

______Bed Mobility ______Stairs/Curbs ______Standing ______Sitting ______Household Chores ______Sleeping

What are your goals for participating in Therapy? ____

____

To the best of my knowledge, I have fully informed you of the history of my problems and current status.

Patient's Signature:____ Date:________________________

***We are required by your insurance company to have your list of medications on file.**

Medications, Over the Counter, Supplements and Herbals	Dosage	Frequency	Route of Administration (ex: Oral, IV, etc.)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practice, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgment, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

____

Please print your name here

____

Signature

____

Date

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below names(s) of the individual(s) you authorize our office to discuss care with. Your PHI may be disclosed to the individuals(s) listed below until you notify us otherwise in writing.

____________________ ____________________

____________________ ____________________

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

☐ The patient refused to sign.

☐ Due to an emergency situation it was not possible to obtain an acknowledgment.

☐ We weren't able to communicate with the patient.

☐ Other *(Please provide specific details)*

____

____

____

______________________________ ____________________

Employee signature Date

HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices 2014.

This form does not constitute legal advice and covers only federal, not state, law.

DAVID STEVENSON PHYSICAL THERAPY, INC
FINANCIAL POLICY

Thank you for choosing us to be your therapy provider. It is important that you understand your financial responsibility before treatment begins, as you are responsible for the timely payment of charges. Please read the following form and do not hesitate to ask us any questions.

MEDICARE: As a participating Medicare provider, we will file your claims. Medicare has a yearly deductible. You are responsible for:

1. any of your yearly deductible met at our office.
2. the 20% percent co-insurance not covered by Medicare.
3. any supplies purchased.
4. any visits over the Medicare fee cap where you were not deemed medically necessary.

PRIVATE INSURANCE: As a courtesy to you, we will file with your primary insurance company. You are responsible at the time of service for any portion your insurance doesn't cover, including any unmet deductible. It is your responsibility to check if we are in network with your insurance plan. As participating providers, we have accepted your insurance company's fee schedule. If you have a copay or cost share, it is payable at each visit. Mailed or emailed statements are due upon receipt.

FOR INSURANCE REQUIRING AUTHORIZATION: If you decide to start your physical therapy prior to your insurance confirming authorization - you will be responsible for any visits not covered and will be charged our self-pay fee schedule.

LIABILITY/AUTO: Effective August 1, 2025 our clinic is unable to accept patients seeking treatment for injuries sustained in a motor vehicle accident, **regardless of PIP status, exhaustion of benefits, or issuance of a PIP exhaustion letter.**

WORKERS COMPENSATION: Excluded from patient payment.

***NOTE: Health insurance is not accepted in place of payment unless we have confirmation from your insurance company that you do indeed have coverage for the procedures being performed. Patients are responsible for any balance on their account not covered or paid by their insurance.**

MEDICAL RECORDS REQUEST: Medical records release form will need to be completed and signed before released. There will be customary and reasonable charges for your records.

CANCELLATION POLICY: A $75 charge will be made for broken appointments unless 24 hours notice is given.

I have read and understand the Financial Policy and agree to abide by it.

________________________________ __________________________

Patient's Signature or Responsible Party Date

Patient name:
Identification number: *(optional)*

David Stevenson Physical Therapy, Inc.
2055 Wood St., Ste. 110, Sarasota, FL 34237
(941) 330-1677

Advance Beneficiary Notice of Non-coverage (ABN)

Medicare doesn't pay for everything, even some care you or your health care provider think you need. **We expect Medicare may not pay for the item, test, service or care listed below.** If Medicare doesn't pay, you may have to pay.

Item, test, service or care	Reason Medicare may not pay	Estimated cost
Outpatient Physical Therapy	Home Health Services Medicare B monies used elsewhere Open MSP (Medicare Secondary Payer)	Initial Evaluation: $180 Follow-ups: $125

What to do now

- Read this notice to make an informed decision about your care.
- Ask any questions you have.
- Choose one option below to let us know if you still want to get the item, test, service or care.

Choose ONE option below. We can't choose for you.

If you choose Option 1 or 2, we may help you use any other insurance you might have, but Medicare can't require us to do this.

○ **Option 1: I want the item, test, service or care listed above, and I want Medicare to be billed for an official decision on payment, which I'll get on a Medicare Summary Notice (MSN).** You can ask to be paid now. I understand that if Medicare doesn't pay, I'm responsible to pay, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you'll refund any payments I made to you, minus co-pays or deductibles.

○ **Option 2: I want the item, test, service or care listed above, but don't bill Medicare.** You can ask to be paid now and I'm responsible to pay. I understand that I can't appeal, since Medicare isn't billed.

○ **Option 3: I don't want the item, test, service or care listed above.** I understand I'm not responsible for payment and I can't appeal to see if Medicare would pay.

Additional information:

This notice gives our opinion, not an official Medicare decision. For other questions about this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. Signing below means you received and understand this notice. You can ask to get a copy.

Signature	**Date** (mm/dd/yyyy)

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. This information collection is for providers, suppliers, Hospice and Religious Non-medical HealthCare Institutes and Home Health Agencies to notify original Medicare beneficiaries of their potential financial liability under specific conditions. The time required to complete this information collection is estimated to average less than 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. This information collection is mandatory under Section 1879 of the Social Security Act, 42 CFR 411.404(b) and (c) and 411.408(d)(2) and (f). If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.