



Increase your well being with Polestar Pilates.

PHYSICAL THERAPY INFORMATION SHEET

Today's Date: _____

Personal Information

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Birth Date: ____/____/____ Phone: _____

Employment Information

Occupation: _____

Employer: _____

Contact information

Work phone: () _____ Ext. _____

Home phone: () _____

Cell phone: () _____

Fax: () _____

Email address: _____

Emergency Contact

Name: _____ Relationship: _____

Phone: () _____ Alternate Phone: () _____

Insurance Information

Referring Physician: _____

Insurance Carrier: _____ Subscriber Name: _____

Group Number: _____ ID Number: _____

Additional Information

How did you find out about us? (check all that apply)

Friend Internet Magazine Newspaper Other: _____

May we send you notices about events, specials, etc? (check) Yes No

If yes, e-mail address _____

therapy



FINANCIAL AGREEMENT

Polestar Physical Therapy & Pilates Center will prepare insurance claims to file to the insurance company as a courtesy to patients. **Please remember that verification of insurance benefits is not a guarantee of payment. You are responsible for the remaining balance, including deductibles and any other non-covered expenses.**

Medicare Authorization

I hereby request that payment of authorized Medicare benefits be made to Polestar Pilates Center, Miami for any services furnished to me by this facility. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for released services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA -1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases the provider or supplier agrees to accept the charge determination on the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance and non covered services. Coinsurance and the deductible are based upon the charge determination of Medicare carrier.

Blue Cross/Blue Shield

BC/BS has a policy that they will reimburse only the patient (the insured) for physical therapy services. Because this is BC/BS's policy, we must request payment for services when rendered.

I hereby assign all medical benefits, including majority medical benefits to which I am entitled including private insurance, any other health plans or insurance coverage to Polestar Pilates Center, Miami, including any settlements from law suits. I understand that I am financially responsible for all charges whether or not they are paid by insurance. I authorize Polestar Pilates Center, Miami to release all information necessary to my insurance to secure payment.

Signature: _____ Date: _____

CONSENT FOR TREATMENT

It is essential that you provide a current prescription for your treatment prior to your first visit. We need your help in securing a new prescription from your doctor if your treatment lasts for more than 30 days. Please ask your therapist for the renewal date of your prescription so that we can insure continuity of treatment.

I am fully aware of my diagnosis and prognosis and I consent to treatment by Polestar Pilates Center, Miami.

Signature: _____ Date: _____

24 HOUR CANCELLATION POLICY

I am aware that if I do not cancel my physical therapy appointment before 3 pm on the day previous to my appointment, I will be responsible for 50% of the payment for the session. I am aware that insurance does not cover any late cancellation charges and it must be paid out-of-pocket.

Signature: _____ Date: _____



MEDICAL SCREENING

PLEASE COMPLETE THIS FORM TO THE BEST OF YOUR ABILITIES AND SIGN THE STATEMENT AT THE BOTTOM OF THE FORM. IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO ASK.

Last Name: _____ First Name: _____

Sex: _____ Marital Status: _____ Number/Age of Children: _____

Hobbies/Recreational Activities and Frequency: _____

Previous Experience with Pilates/Gyrotonics: _____

General Health (Check): ___Excellent ___Good ___Fair ___Poor

Reason for Visit: _____

Goals for Rehabilitation: _____

Medications: _____

Previous Injuries: _____

Previous Surgeries: _____

Are You Currently Receiving Professional Health Care Services (i.e. Chiropractic, Medical, Massage Therapy, Physical Therapy, Etc...): _____

Are You Currently or Have You Previously Been Diagnosed with any of the Following (please check all that apply):

- | | | |
|--|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pregnancy (currently) |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Bowel/Bladder Changes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shoulder Impingement |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Stenosis |
| <input type="checkbox"/> Circulatory Disease | <input type="checkbox"/> Hyperglycemia | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Numbness or Weakness | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Osteoporosis | |
| <input type="checkbox"/> Fainting Disorder | <input type="checkbox"/> Osteopenia | |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoarthritis | |

Other: _____

Is There Anything Else That You Feel We Should Know About or Have Not Asked? If So, Please Explain: _____

I THE UNDERSIGNED, DO HEREBY CERTIFY THAT I HAVE COMPLETED THE ABOVE INFORMATION AND KNOW IT TO BE TRUTHFUL AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Signature: _____ Date: _____



PAIN CHART

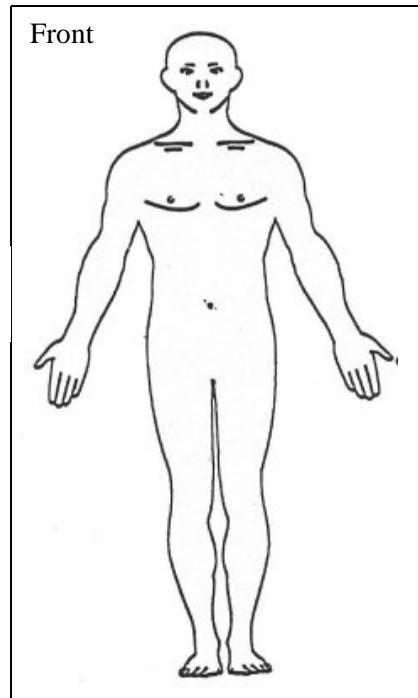
Your Pain Today (please circle closest number):

No	0	1	2	3	4	5	6	7	8	9	10	Worst Pain
Pain												Imaginable

Please indicate the pain intensity at each area circled on the pain diagram by using the pain scale above

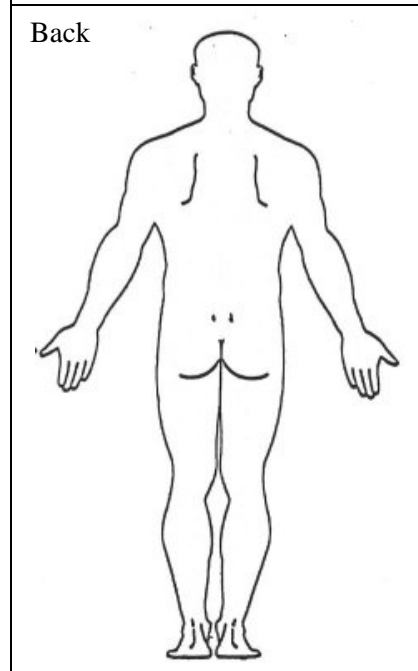
Please Draw Your Pain:
Circle the painful areas below

Key	Painful Area	Intensity Level
1		/10
2		/10
3		/10
4		/10
5		/10



Please enter the pain area number next to any of the words that describes your pain under the column that describes its intensity

	None	Mild	Moderate	Severe
Throbbing				
Shooting				
Stabbing				
Cramping				
Gnawing				
Hot-Burning				
Aching				
Heavy				
Tender				
Splitting				
Tiring				
Sickening				
Fearful				



Your Pain is (please circle the best descriptor):

On Most Days:	No Pain Discomforting Horrible	Mild Distressing Excruciating
At It's Worst:	No Pain Discomforting Horrible	Mild Distressing Excruciating
At It's Best:	No Pain Discomforting Horrible	Mild Distressing Excruciating
Today:	No Pain Discomforting Horrible	Mild Distressing Excruciating